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REAUTHORIZATION OF THE INDIAN HEALTH CARE IMPROVEMENT ACT P.L.94-437

"SPEAKING WITH ONE VOICE IHS, TRIBES, URBAN"

HEALTHY INDIAN PEOPLE AND COMMUNITIES

Roundtable Report

June 8-9, 1998

Rockville, Maryland

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Final Report
A Roundtable Discussion on The Reauthorization of the Indian Health Care Improvement Act, Public Law 94-437 June 8-9, 1998

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'Speaking With One Voice"

EXECUTIVE SUMMARY

Background

On June 8-9, 1998, the Indian Health Service (IHS) convened 'A ***Roundtable to Discuss the Reauthorization of the Indian Health Care Improvement Act, P. L. 94-437. "*** The meeting was held at MS Headquarters in Rockville, Maryland. The focus of the roundtable was the reauthorization of the Indian Health Care Improvement Act (IHCIA), Public Law ***94-437,*** which is up for reauthorization in the next session of Congress. This Act funds health care services provided to and for American Indians and Alaskan Natives in the United States at the local, area and national levels. The annual funding appropriation for the IHS is approximately $2.2 billion dollars which provides health services to over 1.5 million Indian and Alaska Native beneficiaries served by Indian Health Service, Tribal, and Urban (I/T/U) health programs each year. The Indian Health Care Improvement Act represents one of the most critically important pieces of legislation affecting Indian health today. Originally enacted in 1976, the IHCIA provides comprehensive statutory authority for a variety of health programs. While there have been substantial improvements in health status, American Indians and Alaska Natives still lag far behind that of all other races in the United States. With shrinking federal appropriations for the MS, the job of maintaining and improving health status is becoming far more diicult.

Purpose

The Roundtable brought together approximately 25 participants from the field of Indian health care delivery and program services. Each participant brought extensive background and expertise in the Indian health care field as tribal leaders, health care providers, public health administrators, urban program directors, and Congressional technical advisors. The participants were asked to think globally and futuristically about the national health care environment as it is currently evolving, and the applicability of those effects and results on Indian health care. The purpose of the Roundtable was to stimulate discussion and recommendations regarding the Indian Health Care Improvement Act (IHCIA) that would result in a base of information from which the MS will begin to plan a tribal consultation process. The expiration of the IHCIA in fiscal year 2000 is of great concern to the participants of this roundtable discussion. The results of this discussion will assist the MS and local tribal and urban health officials define the many issues involved in the

pending reauthorization; changes in the health care environment affecting Indian health today; and an analysis of the of the opportunities presented through the passage of comprehensive health care legislation.

The upcoming reauthorization of the Act provides opportunities for the Indian Health Service, tribes and urban providers (I/T/U's) to be creative in updating the legislative authority. Participants in this roundtable were asked to be open-minded in their analysis of the reauthorization. The roundtable was given the following directive:

- Take a global view of the reauthorization process and look futuristically, thinking of Indian health care over the next 10 to 20 years. Be creative;
- Identify environmental influences and changes in the health care industry and the impact on I/T/U systems;
- Look at the reauthorization process and identify opportunities for change;
- Envision how 'Indian Country' will work with U.S. Congressional committees;
- Identify the 'key issues' and goals of the new legislation;
- Provide guidance to the IHS on how to proceed with a consultation process;
- Discuss emerging trends and how they impact on Indian health care, such as managed care, state health and welfare reforms, increased tribal contracting and compacting;
- Don't limit discussion to existing provisions of the IHCIA, but keep an open mind and be solution oriented.

Recommendations of the Roundtable

The Roundtable participants identified health care issues into two major areas. Each of these major areas was reviewed in detail by subgoups of the roundtable participants. The two groups are (1) Patient Bill of Rights for Indian People; and (2) Changing Health Care Environment.

"Patient Bill of Rights for Indian People"

Purpose: To examine the feasibility of establishing a guaranteed level of health care benefits, including emphasis on prevention for all American Indian and Alaska Native beneficiaries of the I/T/U system. To be successful, this effort would require a definition of the "standard services" **or guaranteed package of benefits, which are available. Second, these services must be articulated to the beneficiaries, so that there is adequate understanding from the users of the I/T/U system. Finally, a mechanism for the continual monitoring and evaluation of services should be in place, so that services could improve based upon the needs and input of patients, not the shortcomings of federal budgets.**

1. Political Environment

- The basic rights and needs of American Indians and Alaska Native for health services have been overshadowed in the political environment. A Patient's Bill of Rights must ensure that Congress, the Administration and those charged with administering the trust responsibilities of the federal government are cognizant of the impact cuts to the I/T/u system have on the health care of Indian families. The political and legislative process needs to be more responsive to situation of Indian health systems..
- The reauthorization process should avoid legislating internal operational procedures and requirements in the law. The new Act should stand the test of time, provide fundamental policy and mandates regarding the protection and enhancement of Indian health, and avoid operational issues.
- American Indian and Alaska Native leaders should examine which programs have been successful in realizing substantial budget increases, such as the National Institutes of Health (NIH), AIDS Research, women's health, immunization initiatives, child health insurance, and which have been losers, such as the IHS budget. Examine the reasons why some health issues prevail in the political process and others do not.
- Consider transferring the duties for appropriating funds for Indian Health Service out of the Interior Appropriations Subcommittee and into the Labor, Health and Human Services Appropriations Subcommittee, which handles all other health, related appropriations. Under this scenario, the MS would be balanced against other federal health programs in the allocation of funds, instead of shifting funds from BIA or other Interior Department programs to restore MS budget cuts.
- Within the Department of Health and Human Services, examine the role of Public Affairs Office in addition to the Management and Budget Office, when educating federal officials about the needs of Indian patients and the need for appropriate funding for the I/T/U systems.
- Balance of power has been shifted to states in area of health care, particularly with regard to Medicaid related programs. Indian patients as Medicaid beneficiaries are entitled to Medicaid covered services and the I/T/U systems are entitled to be reimbursed for these services. More attention should be given to protecting Indian patient rights and provider rights under state administered systems.

2. Refocus Act on Prevention and Other Issues

- Indian and Alaska Native patients have a right to have high quality and comprehensive prevention services available through their community I/T/U system.. A shift in focus in the IHCIA toward preventive measures is

appropriate given the types of health problems experienced by native populations.

- Access to more comprehensive health care is a right of American Indii and Alaska Native patients. An effort to balance the scope of services across the board should be a priority.
- Elderly patient care should be evaluated to ensure high quality and appropriate scope of services is provided. The changing nature of health problems experienced by Indian elderly, might suggest new strategies and more community-based intervention.
- Identity why the Act is currently not working, that is which programs work and which do not. Assess how it can be re-designed to give both tribal and urban access to contracting under self-determination.
- Focus IHCIA priorities on meeting needs of the patient base. The unmet health needs of American Indianand Alaska Native communities should dictate the priorities of the new legislation. Quality of care from the perspective of the patient should be considered.

3. Public Health Infrastructure

- The provision of basic public health functions under the umbrella of the Indian Health Service has been a major benefit to the elevation of Indian health status through environmental improvements. Preservation of the public health infrastructure within the context of increased tribal self-determination contracting and self-governance compacting is important to consider, and if necessary ensure adequate legislative provisions for the public health and environmental safety of Indian communities to continue.

4. Community Ownership of Health Care Delivery Systems

- Innovative, community-based strategies for the development of comprehensive health services should be fostered and expanded under the IHCIA. An assessment of innovative strategies should be conducted for consideration of how I/T/U systems could better organize and manage their health services.

5. Urban Programs

- Allow for expanded considerations of the relationship of urban health programs under the I/T/U structure, and how urban programs relate to the Indian Self-Determination Act. The rights of patients residing in urban areas should be considered. They are still enrolled tribal members and there should be some re-assessment of eligibility and funding for services that respects the rights of urban patients.

6. Managed Care

- Over 80% of Americans now receive their health services through some sort of "managed care organization". States are increasingly implementing mandatory managed care in their state Medicaid programs, thereby, purchasing through managed care organizations and requiring Medicaid patients to enroll. The I/T/U systems are becoming more and more dependent upon the third party payor to reimburse for covered services. The IHCIA reauthorization process should include some assessment of managed care on Indian patient rights, and whether our I/T/U systems are adequately prepared to compete in a managed care system. And provide for the policy development to assure the protection of the I/T/U infrastructure and its enhancement in the future.

7. Partnering - Federal, State, Tribal Governments and I/T/U System

- The provision of health services to Indian patients goes beyond the scope of IHS resources. The IHCIA should include an assessment of all federal, state and local resources, which combine to assist Indian patients. Legislation, which will improve the position of I/T/U's to negotiate benefits for Indian and Alaska Native patients, is recommended. Agencies, such as the Health Care, Financing Administration play major roles in the effort to improve Indian health. Federal legislation should be considered to eliminate roadblocks experienced in many of these agencies and create policy and program opportunities for collaboration.

8. Psychosocial and Behavioral Health Areas

- The task of elevating Indian health status goes beyond the provision of clinical services. Other social issues and factors include family violence, substance abuse, injury issues, lack of viable economic development ventures, etc. The IHCIA should expand the resources available to I/T/U's to intervene in the psychosocial or behavioral health areas.

9. Tribal Self-Determination and Self-Governance

- There should not be penalties for those tribes opting to contract, compact or receive services through the Indian Health Service. Provisions should be considered which will ensure equity for all partners in the I/T/U system, regardless of which administrative mechanism each chooses. The basic rights of Indian and Alaska Native patients to health care, should not be dramatically affected by the contracting methods employed to deliver services.

10. Cost Factors

- The I/T/U system is on the losing end of virtually all health care financing systems currently being applied. The Balanced Budget Agreement has eliminated any hope that the I/T/U's will receive needed increases to keep pace

with inflation and population growth. Federal administrative initiatives, such as "Reinventing Government" and GPRA further threaten the MS structure within the Public Health Service. Welfare Reform has increased the demand on the I/T/U mental health and alcohol services, without proportionate increases in resources. Welfare Reform has also triggered a drop in Medicaid enrollments in each state and Medicaid managed care has reduced revenue, thus depleting I/T/U anticipated revenues. The financing systems are driving a reduction in services to American Indian and Alaska Native patients. Our patients should have an "entitlement" to health services and be fully recognized as Medicaid and Medicare patients, when they are eligible.

8. Other Factors

- Federal Tort Claims Act coverage under the I/T/U system should be evaluated to ensure it is adequately covering all providers and ensuring the protection of patient's right to access high quality care and due process for patient claims. FTCA coverage should be extended to urban providers under the I/T/U.
- The formal consultation policy developed by Secretary Donna Shalala (DHHS) should be included in the regional consultation meetings pertaining to the reauthorization of the Indian Health Care Improvement Act.
- Elevation of IHS Director within DHHS to an Assistant Secretary position is absolutely critical to ensure the rights of our patients are protected at the highest levels of budget deliberation.

"Changing Health Care Environment"

Purpose: These recommendations are designed to identity key changes in our health care environment, including public health and clinical services; and identify key health care delivery issues related to Urban Indians. These recommendations address issues related to our "entitlement" to health services; the ability of our patients to access basic services within the I/T/U network; and financial barriers and proposed solutions to improve the financing of VT/U systems.

1. Facilities

- New and innovative facility construction financing options should be examined for inclusion in the reauthorization of the IHCIA. There may be different approaches for the diierent problems to address tribal and urban facility needs. Consider establishing a capital loan from loan guaranteed programs with emphasis on ambulatory care facilities: Consider balanced, fair approach to fund all types of facilities construction, so majority of money doesn't go to just one type of facility.
- Include Joint Venture Demonstration projects as a permanent part of the IHCIA, which will allow tribes and urban programs to fund the expansion or replacement of their facilities and be ensured adequate staffing and equipment through the MS, as partners in the overall system.
- Consider other capital projects such as management information systems, integrated service delivery development, etc.

2. Health Care and Manpower Issues

- The JHCIA should exempt all direct health care providers from any restrictions on Full-Time Equivalent ceilings imposed by the Administration or through federal law.
- The IHCIA should include a Mentor Program to assist Indians going through health professional programs, include leadership training.
- Remove impediients from current legislation on how the loan repayment program money is being allocated; let it be driven more by where manpower needs really are.

3. Political Strategy for Indian Access to Other Funding Programs

- Need to develop political strategy to access other funding programs. Some of this might be accomplished through legislative language in the IHCIA reauthorization. Also, from resources available through Health Services and Resources Administration and being tapped into for Historically Black Colleges and Universities (HBCU). Tap into those resources for Indian tribal colleges and universities to create opportunities and incentives

4. Billing, Reimbursement and Financing

- Health care providers and I/T/Us should have the right to reasonable cost reimbursement under Medicaid and Medicare and authority to receive reimbursements directly from the Health Care Financing Administration (HFCA), by-passing the States. Search out successful demonstrations that have'occurred and **consider new an innovative legislation to bring I/T/U's on a level playing field with states in regards to Medicaid administration.**

- Include amendments to IHCIA to allow MS or tribal Self-Determination Act contractors to bii tribal employee insurance programs and self-insurance programs, if authorized by the tribal government. Eliminate or amend the current prohibition in the IHCIA against billing tribal self-insurance programs.
- Permit I/T/U's to bill each other for services provided to Indians from other I/T/U systems.
- Exempt tribes and Indians from costs of premiums they are currently required to pay in Children's Health Insurance Program (C.H.I.P.), Medicare -Part B., etc. Our right to health care has already been pre-paid.
- Tribe must receive full Contract Support Costs in compliance with amendments to the Indian Self-Determination Act, when contracting and taking over the administration of IHS services. The inability of Congress to keep pace with CSC, is creating a depletion in overall resources for delivery of services to American Indians and Alaska Natives. The problem of funding for CSC expenses must be dealt with in the IHCIA.

5. **Urban Issues**

- Urban Indian providers have not been provided full opportunity for consultation; Urban Indians should not lose their right to be a part of consultation when they leave the reservation.
- Clarify the rights and benefits of urban patients and urban health providers under the new IHCIA. Urban Indian populations should be included in the allocation formula of the Indian Health Service to ensure adequate funding for all Indian and Alaska Native people, regardless of residence. Urban programs should receive funding based upon user populations and be able to provide the full range of services to patients.
- Expand and make permanent the two urban demonstration projects in Oklahoma. These projects have proven that urban providers can be merged into the overall I/T/U system successfully.
- Amend the Federal Tort Claims Act to include FTCA coverage for urban contractors under Title V of the IHCIA, just as the MS and tribal contractors are now covered.

6. **Access To Health Care**

- The allocation of health care services and resources should be based upon tribal enrollment and not geographical location. Contract Health Service Delivery Area (CHSDA) should follow the individual regardless of residence. Access to I/T/U services should be an "entitlement" for enrolled Indian and Alaska Native people. The eligibility criteria is too vague and needs to be more clearly defined.
- Medicaid/Medicare eligibility mechanism needs to be strengthened, including I/T/U authority for on-site eligibility determinations. Amendments to federal

law beyond IHCIA should be examined to achieve better access by I/T/U patients to Medicaid and Medicare covered services and payments.

- Language and authority is recommended to allow the I/T/Us to purchase health care and health care insurance and to provide it under the Indian Health Service system.
- Third-party collections should not be used to offset MS budget. There should be a legal prohibition against offsetting the IHS budget with projections of third party revenues.
- Need specific language for access of I/T/U's to all special initiative funds such as the Tobacco Settlement legislation, which should include direct access for I/T/U's, bypassing States.

7. **Managed Care**

- Federal law should be amended to provide for a direct set-aside at the national level for all Medicaid and Medicare payments to I/T/U's to be centrally administered through the MS for the benefit of I/T/U's and their Indian and Alaska Native patients. I/T/U's should not be forced to negotiate with states or state contractors for reimbursement of services.
- Short of a direct set-aside, Federal law should be amended so that states are required to contract with I/T/U's for the provision of health care to Indian Medicaid beneficiaries who are patients of the I/T/U system. It should not be allowable under federal law to have Indian patients arbitrarily assigned to other managed care providers of the state, and I/T/U's suffer a loss in revenues. In most cases, Indian patients continue to utilize the I/T/U, but their Medicaid reimbursement is lost due to arbitrary assignments to other MCO's.
- Freestanding I/T/U clinics, should be able to bill Medicare-Part B.
- Legislation is need to allow I/T/U's to assume risk and have their own managed care plans, including the need to amend the Anti-Deficiency Act to eliminate impediments that keeps I/T/U's from taking on these capitated, managed care ventures.
- Tribes need investment risk capital for development of plans and reserves for carrying risk
- Adjustment on capitation rates for I/T/U's should be provided in federal law to ensure that even under a capitated system, the I/T/U's are more likely to receive 100% reimbursement for high-risk populations. Through a risk adjusted capitation or a Federal wrap-around, the reasonable cost levels.

8. **Prevention and Public Health Care Services**

- The IHCIA should provide that I/T/U's have access to all Federal program services and funds under public Health Service. If funds are available to States, they should be made available to I/T/U's.

- Access and coordination with other services by other departments and programs to better utilize available resources, i.e., Veterans Administration, etc. should be included in the IHCIA reauthorization.
- Departments and agencies of the federal government should be required accountability to I/T/Us for funds they received that address Indian health care issues, i.e., research funds, Center for Disease Control, etc.

9. **Data and Technology**

- Legislative language needs to specifically instruct and require the Public Health Service (PHS) to collect more comprehensive data and statistics on American Indians and Alaska Natives. Need to have a comprehensive assessment of what is going on in Indian Country. Currently, there is concern over accuracy and scope of available PHS data. MS (RPMS), tribal and urban systems collect different types of data; need national data set and repository; need common indicators. I/T/Us should have access to Center for Disease Control (CDC) data systems
- Legislative language should include access to new technology as it becomes available to enable I/T/U's to provide better and more comprehensive health care services.

10. Long-Term Health Care

- Explore long-term demonstration projects to provide national and legislative authority for tribes to have flexibility, i.e., provision for home and community-based care and other long-term services. Would enable Tribe to identify what their most important needs are. Also, need to maximize Medicare and Medicaid as these programs have responsibiity for covering these services.

The roundtable recommended that the MS begin an Area by Area consultation process and provided specific recommendations on how those meetings should be held. The culmination of these Area and Regional consultation meetings is expected to be the drafting of legislation which reflects the concerns and needs of tribal and urban health providers, and is consistent with the changes in health care nationally. The Roundtable participants provided suggestions and recommendations in regard to conducting tribal and urban consultation meetings. Their comments were grouped into the following 10 topics:

1. Agenda
2. Asking for Support
3. Atmosphere and Setting of the Consultation Meetings
4. Considerations for the Content of the Bill
5. Developing Support for Reauthorization Orientation For All Those in the Reauthorization Process

(MORE)

6. Materials and Information for Tribal Consultation Meetings
7. Preliminary Activities to Tribal Consultation Meetings
8. Regional and Tribal Differences
9. Tribal Consultation Process
10. Urban Health

The analyses and information from the Roundtable is intended to stimulate discussion and provide a framework for consultation to advance. It is of critical importance that the I/T/U leadership work together to ensure that the new Indian Health Care Improvement Act is reflective of the health care needs of Indian communities for the next 15 to 20 years. The IHCIA is one of the most important pieces of federal Indian law supporting our communities today. Efforts to ensure the continuation of a comprehensive health care statute should be carried out in a unified and thoughtful process. In concluding the roundtable meeting, the IHS Director offered the suggestion that Indian country would be best served for all stake-holders in the reauthorization process to be "speaking with one voice".

* * * * * * * *

A Roundtable Discussion On

The Reauthorization of the Indian Health Care Improvement Act, P. L. 94-437

"Speaking With One Voice"

I. INTRODUCTION

The U.S. Indian Health Service has initiated a series of roundtable discussions over the last several years as a means to convene leading experts from the fields of Indian health, community development, Indian law, research, academia, tribal and urban health leadership, and the larger health industry to examine current and sometimes controversial topics related to Indian health care. On June 8-9, 1998, for a day and a half the Indian Health Service (IHS) convened ***"A Roundtable to Discuss the Reauthorization of the Indian Health Care Improvement Act, P.L.*** 9443% " The meeting was held at MS Headquarters in Rockville, Maryland. This meeting was convened to provide the IHS and others the opportunity to discuss the reauthorization of the Indian Health Care Improvement Act, which is authorized until fiscal year 2000. First enacted in 1976, the Jndian Health Care Improvement Act represents one of the most critical foundations shaping Indian health services and improvement of Jndian health status today.

The Roundtable convened approximately 25 participants from the field of Indian Health care delivery and program services. Participants reflected a variety of experiences, perspectives and expertise in the Indian health care field. They represented tribal leaders, urban and rural health care providers, public health administrators, and U.S. Congressional staff from relevant committees. A cross-section of the existing network of Indian Health Service, tribal and urban health providers (I/T/U's) were recruited to participate in this important roundtable discussion.

The purpose of the Roundtable was to stimulate discussion and recommendations regarding the Indian Health Care Improvement Act (IHCIA) that would result in a base of information from which the MS will begin to plan a tribal consultation process. The expiration of the IHCIA in fiscal year 2000 is of great concern to the participants of this roundtable discussion. The results of this discussion will assist the MS and local tribal and urban health officials define the many issues involved in the pending reauthorization; changes in the health care environment affecting Indian health today; and an analysis of the of the opportunities presented through the passage of comprehensive health care legislation.

The upcoming reauthorization of the Act provides opportunities for the Indian Health Service, tribes and urban providers (I/T/U's) to be creative in updating the legislative

authority. Participants in this roundtable were asked to be open-minded in their analysis of the reauthorization. The roundtable was given the following directive:

- Take a global view of the reauthorization process and look futuristically, thinking of Indian health care over the next 10 to 20 years. Be creative;
- Identify environmental influences and changes in the health care industry and the impact on I/T/U systems;
- Look at the reauthorization process and identify opportunities for change;
- Envision how 'Indian Country' will work with U.S. Congressional committees;
- Identify the 'key issues' and goals of the new legislation;
- Provide guidance to the IHS on how to proceed with a consultation process;
- Discuss emerging trends and how they impact on Indian health care, such as managed care, state health and welfare reforms, increased tribal contracting and compacting;
- Don't limit discussion to existing provisions of the IHCIA, but keep an open mind and be solution oriented.

These discussions will help form the framework upon which the MS will conduct consultation and further develop an approach to revising or reauthorizing the IHCIA. With the results of this roundtable, the IHS will conduct tribal and urban consultation meetings across the United States. Recommendations from the tribal and urban consultation meetings will be incorporated and reflected in the content and structure of the new Indian health legislation.

II. BACKGROUND ON INDIAN HEALTH CARE

The United States maintains a legal and moral responsibility to provide health services to America's Indian and Alaska Native population. These obligations are based upon numerous treaties signed between the U.S. and tribes which ceded millions of acres of land in exchange for certain reserved rights and basic provisions guaranteed by the United States, including health care. The unique relationship between tribes and the Unites States is underscored in the U.S. Constitution (Article I, Section 8). Federal laws and court decisions have confirmed the unique relationship between tribes and the federal government, and upheld the obligation of the United States to provide health services to American Indians and Alaska Natives.

The provision of health services to American Indians began during the Indian war era and continued through the turn of the century. For most Indian tribes the devastation of new diseases, wars, forced relocations and cultural upheaval had a drastic impact on the health and well being of the tribe. In 1921, President Hoover signed into law the Snyder Act, which provides the underpinning for a variety of federal Indian programs, including the Indian Health Service. The Snyder Act provided, *"...such sums as Congress, may from time to time appropriate for the benefit care and assistance of Indians".* The transfer of

these responsibilities to the U.S. Public Health Service in 1955 sparked the beginning of the U.S. Indian Health Service, and a slow but measured rebound in the health status of American Indians today.

The legislative history of Indian health care, can be traced back to the Snyder Act in 1921. Only the Indian Health Care Improvement Act has provided more direction and foundation for the improvement of Indian health status.

- **The Snyder Act of 1921 (25 U.S.C. 13)**
  The Snyder Act authorizes Congress to appropriate funds for the "relief of distress and conservation of health and for the employment of physicians" for Indians through-out the United States. It represents permanent statutory authority for Indian health programs.

- **The Johnson O'Malley Act of 1934, Amended 1936 (25 U.S.C. 452)**
  The JOM Act authorizes the Secretary of the Interior to contract with states and other local governments to provide education, medical attention, agricultural assistance and social welfare for Indian people in hardships related to the allotment process or other hardships related to Indians living off the reservation.

- **The Transfer Act of 1954, Amended 1973, (42 U.S.C. 2001 et seq.)**
  The Act established the U.S. Indian Health Service under the Department of Health, Education and Welfare, and removed responsibilities for Indian health services from the Department of Interior.

- **Indian Health Facilities Act of 1957 (42 U.S.C. 2005)**
  This Act provides the MS with the authority to fund construction of hospitals for the benefit of Indian tribal patients.

- **The Indian Sanitation Facilities and Services Act of 1959, (42 U.S.C. 2004)**
  This federal law expanded the duties of the IHS to ensure public health requirements were being met, including safe and sanitary drinking water, sewer systems, drainage facilities, waste and access to of water and sewer systems for Indian homes.

- **Public Law 91-224 of 1970, (16 U.S.C. 459; 33 U.S.C. 446; 31 U.S.C. 529; 41 U.S.C. 5)**
  This law provided authority for the Departments of Interior and Health and Human Services to collaborate on demonstration projects, which would provide central community systems for safe drinking water in Alaska Native villages.

- **The Indian Self-Determination and Education Assistance Act of 1975, Amended in 1988 and 1994, (25 U.S.C. 450 et seq)**
  The Act authorizes federally recognized Indian tribes the means to contract with the federal government for the purpose of administering and operating federal programs, services, functions and activities which were established to serve that tribe.

- **The Indian Health Care Improvement Act of 1976, Amended 1980, 1988, 1990 and 1992 (25 U.S.C. 1601 et seq)**
  This was landmark legislation, which elevated and invigorated Indian health care improvement measures to a higher level within Indian communities and within the federal government. The Act provided clear policy for the Nation to elevate the health status of Indians and Alaska Natives to the highest possible level. The Act set out specific new programs and initiatives, which will be described in detail in a later section.

- **Indian Alcohol and Substance Abuse Prevention and Treatment Act, (Subtitle C of the Omnibus Drug Act o f 1986: P. L.** 99-570, **Amended in 1988, 1990 and 1992)**
  This Act provided specific authorizations to address the problem of alcoholism, alcohol abuse and drug abuse in Native American communities. Each tribe developed an action plan to combat addictions, and inpatient treatment centers for Indian adolescents were authorized.

The MS is an agency established under the U.S. Public Health Service within the Department of Health and Human Services (DHHS). The mission of the MS is to provide a comprehensive health service delivery system for American Indians and Alaska Natives. The range of services provided through the IHS includes a broad spectrum of preventive, curative, rehabilitative and environmental services. The transfer of federal health activities for Indians from the Interior Department to the Public Health Service was a major event resulting in a formalized, structured and vastly improved Indian health system. The IHS has developed a model of service delivery, which incorporates direct outpatient and inpatient facilities, contracting for the provision of services from the private sector, contracting with tribes and urban providers of health services. The IHS approach is comprehensive and includes public health nurses, community health representatives, sanitation initiatives and housing quarters for providers in rural remote areas.

The IHS provides health services through 144 Service Units which are composed of more than 500 direct healthcare delivery facilities, including 49 hospitals, 190 health centers, 7 school health centers, and 287 health stations, satellite clinics, and Alaska village clinics. In addition to direct services provided by IHS, within the system 1) Indian tribes deliver MS funded services to their own communities with about 35 percent of the IHS direct

services budget in 11 hospitals, 129 health centers, 3 school health centers, and 240 health stations; 2) various health care and referral services are provided to Indian people away from the reservation settings through 34 urban center programs; and, 3) the purchase of contract health services from non-IHS providers to support, or in some cases in lieu of, direct care services that MS is unable to provide in its facilities.

Many of the American Indian and Alaska Native people served by the MS live in some of the most remote and poverty stricken areas of the United States. For them, the MS represents the only source of health care available. Others reside in larger communities but face cultural or financial barriers to care. While the IHS represents the primary health resource for most Indian people in the U.S., Indian people are also eligible for a variety of alternate resources, such as Medicaid, Medicare, state programs and private insurance. The MS requires beneficiaries to exhaust these alternate resources before expending contract health resources. For federal, tribal and urban providers of services under the MS, this myriad of alternate resources and requirement makes providing vital health services to American Indians and, Alaska Natives a challenge.

Improvements in health outcomes between the years 1972 and 1993 records indicate the following:

- Infant mortality was reduced by 54%
- Years Potential Life increased by 54%
- Overall mortality was reduced by 42%
- Maternal mortality was reduced by 65%
- Gastrointestinal disease mortality was reduced by 75%
- Tuberculosis Mortality rate was decreased by 80%.

American Indians and Alaska Natives, while improving in health status since 1972, remain one of the most vulnerable populations in the United States. Dying at rates higher than other racial groups in America in many categories.

- The median age for Indians living in the 34 reservation States Indian Health Services provides services for is 24.2 compared to 32.9 for the U.S. All Races and 34.4 for the White Race.

- For Indians, 33 percent of the population was younger than 15 years and 6 percent was older than 64 years. For the U.S. All Races population, the corresponding percentages were 22 and 13, respectively.

- According to the 1990 Census, the median household income in 1989 for Indians residing in the current Reservation States was $19,897, compared with $30,056 for the U.S. All Races population. During this period, 3 1.6 percent of Indians lived below the poverty level, in contrast to 13.1 percent for the U.S. All Races population.

Indian mortality rates for certain causes (*) outpace all races in the United States. In particular, deaths due to accidents, chronic liver disease (cirrhosis) and diabetes rank among the most alarming:

Age-Adjusted Mortality Rates (Rate per 100,000 Population) 1991 - 1993

Cause of Death	AI/AN Rate	U.S. All Races	Ratio to U.S.
All Causes	594.1	504.5	1.2
Major cardiovascular diseases	165.5	180.4	0.9
Malignant neoplasms	98.8	133.1	0.7
Accidents	83.4	29.4	2.8 *
Chronic Liver Disease/Cirrhosis	30.1	8.0	3.8 *
Diabetes mellitus	31.7	11.9	2.7 *
Pneumonia/influenza	19.2	12.7	1.5 *
Suicide	16.2	11.1	1.5 *
Homicide	14.6	10.5	1.4 *
Chronic obstruct/pulmonary	14.8	19.9	0.7
Tuberculosis	2.1	0.4	5.3 *
HIV	2.7	12.6	0.2

III. DISCUSSION OF MAJOR ISSUES FACING INDIAN HEALTH TODAY

Roundtable participant discussed a variety of topics related to the reauthorization of the Indian Health Care Improvement Act.. The following is a summary of those discussions.

- Current Federal Policy: The current Indian Health Care Improvement Act reflects an ongoing federal commitment to improve the health status of American Indians and Alaska Natives. There should be no retreat from this position, but an expansion on existing policy. The Act includes a number of important provisions, which have helped form, the infrastructure of the I/T/U system today. It should be made clear in future amendments that American Indians and Alaska Natives have already pre-paid for their health care through the loss of millions of acres of land.

- Inadequate Funding for Indian Health: The impact of federal budget cuts to the U.S. Indian Health Service has been staggering. The annual expenditure on health services for MS beneficiaries was 75% of the national per capita expenditure in 1975, as reported in the 1986 report, "Bridging the Cap: Report of the Task Force on Parity of Indian Health Services". Today, the per capita expenditure for American Indian and Alaska Native patients of the IHS has dropped to just one-third of what other Americans spend on their health care per person. Even among other federal health systems, such as Medicaid and the Veteran's Administration, the per capita expenditures for beneficiaries of these systems outpace American Indians and Alaska Natives by three times, according to

National Indian Health Board studies. Federal budget cuts have cost the Indian Health Service in dollars and staffing. The IHS budget is targeted to receive no substantial increases through the year 2002. Yet, the cost to provide the same level of services increases annually, the I/T/U system must provide pay increases to federal employees and continue to purchase services from an increasingly expensive health care industry.

- **State Tribal Funding:** The new reauthorization should also consider how tribes are treated differently from state to state in regards to state administered systems. This problem should be rectified ifpossible. Consideration should be given to Congress taking Medicaid and Medicare money proportionate to Indian needs and giving it to MS to administer rather than HCFA who goes through the States.

- Increasing **Patient Needs: The I/T/U** system is funded at levels, which are estimated to meet approximately 60% of actual patient needs. The rate of need funded varies from Area to Area within the MS system, depending on patient access to major facilities. The population base of eligible patients is increasing at a rate of 2.1% per year, not counting the impact of newly recognized Indian tribes. The IHS budget has not increased at that same rate to keep pace with the growing patient demand. While Indian mortality statistics are still alarming, Indian and Alaska Native people are living longer today than we did in **1955. While** this is good news, it also requires the I/T/U system to be prepared for more patients with chronic diseases and more complicated and more expensive interventions. At the same time our knowledge and understanding of major health problems reveals that the leadii causes of death and disease among Indian and Alaska Native people is preventable and lifestyle related. Comprehensive, culturally sensitive prevention programs present the greatest opportunity to make long lasting improvements in health status. Unfortunately, with a severely under funded system, where services are rationed though-out the year, prevention activities sometimes take a back seat to high cost and urgent care.

- **Tribal Contracting and Compacting:** Amendments to the Indian Self-Determination Act have created new opportunities for tribal governments to assume control and management of Indian health services. Tribes are not bound by many of the restrictions of the MS when administering Indian Self-Determination Act contracts or Self-Governance compacts. Today, close to **40%** of the total MS budget is under a tribal contract or compact, with anticipated increases in the number **of tribes administering their own health systems. As tribes** exercise their right to contract or compact programs, services, functions or activities of the MS, tribes are also entitled to receive their proportionate "tribal shares" from MS Area and Headquarters budgets. The Indian Health Service is adjusting to these incremental reductions at Headquarters and Area levels. Tribes are also entitled to receive funding over and above the dollars administered by the MS, to cover new costs associated with tribal administration of the system.

Amendments to the law require that tribal contracting not diminish the funding available for service delivery, and instructs that new funds, called "Contract Support Costs" (CSC) be provided to tribes. The amount of annual Congressional appropriations for CSC has not kept pace with the number of tribes contracting. A waiting list has evolved, leaving many tribes to wait five to seven years for their administrative and CSC costs to be covered. The future of CSC funding for tribes remains unclear, as Congressional appropriations committees assess various CSC reallocation proposals. The intent of the law, however, was to ensure adequate funding for tribal contracts and compacts to be implemented without a diiution in services for patients. Without full funding for CSC, it may not be possible to achieve this mandate.

- **IHS Restructuring:** In 1995, the Indian Health Service released a final report from its Indian Health Design Team (IHDT), which was described as *"....the first attempt in* 40 years *to change the overall structure of the IHS..."*. It represented a partnership of MS, tribal and urban health providers, and responded to the increasing pressures on the MS to redesign. Three major forces were impacting the MS. They were (1) increased tribal contracting and compacting; (2) rapid *changes* and inflation in the health care industry; (3) federal downsizing initiatives of the Clinton Administration. The first phase of the redesign was to downsize and restructure MS-Headquarters. The second phase involves Area and local redesign and is being handled on an Area by Area basis with the involvement and consultation of tribes and urban health providers.

- **Complexity and Disparity in the System:** The I/T/U system has been described as "a mile wide and an inch deep". The system serves a large and diverse patient population in vastly different regions of the United States, with way too little resources. There is no single guaranteed benefit package for all IHS beneficiaries. Services are rationed baaed upon annual Congressional appropriations and geographical access to larger IHS or tribally operated medical centers and clinics. The amount of funds provided to each region varies on a per capita basis. Some areas operate no IHS facilities, while others include large IHS inpatient medical centers. Tribal contracting and compacting is more frequents in some areas than others. Urban Indian health providers are scattered across the map in 34 cities, and serve large numbers of patients with less than 1% of the total IHS budget.

- **Managed Care:** Managed care is having a great impact on I/T/U systems across the United States. The increasing reliance on third party reimbursement systems, such as Medicaid, Medicare and private insurance has accelerated the move of I/T/U's into the managed care field. I./T/U providers are finding themselves in a position of competing for their own patients against large managed care organizations. States have not always consulted with I/T/U's in the planning and implementation of state health reforms, including changes in how Medicaid is administered. For many tribal and urban providers, this has resulted in a loss in revenues and confusion and reduced access for their patients.

- **Media and Communications:** Most I/T/U providers have not benefited fiom improved and advanced media and communication technology. A special emphasis is needed to bring disease prevention and health promotion materials to our patients at home and in the waiting rooms. Computerized, multimedia options should be available to our patients in most of our facilities, just as it is in other facilities. Prevention efforts must be evaluated and reconfigured to better fit with our information age.

- **Partnering: As** tribes and urban providers assume more control over the Indian health system, there is a need for innovative approaches to provide services. There have not been adequate incentives to encourage inter-tribal or tribal/urban ventures in the delivery of comprehensive health care delivery systems. The Indian Health Care Improvement Act should assess the changing health care environment and provide incentives for partnering among various components of the I/T/U structure.

- **Urban Populations: The** lack of consistency in how tribes and urban health providers are treated should be examined. States, in particular deal with tribes and urban providers differently from state to state. The Indian Health Service, also treats tribal providers different from urban providers. The roundtable participant's question whether there can be a consistent policy developed which will clarify the relationship of the providers within the I/T/U system. Urban Indian populations reflect a large percentage of the overall MS beneficiaries, yet the allocation of resources continues to be minimal in comparison.

- **Expand Our Resource Base:** One of the largest challenges facing Indian health care providers is finding ways to expand the base of resources and funding to support services. The flat-line budget of the Indian Health Service, suggests that increases in resources must come from expanding our third party revenues and involving other federal or state health care initiatives in our effort. For many tribes, who have contracted or compacted the delivery of health services, they are finding themselves subsidizing these services with other tribal revenues. The long-term impact of this approach could devastate many tribes. Other federal agencies with health care mandates, should be required to include American Indian and Alaska Native populations in their funding system. These alternate fund sources should be researched and if **necessary,** changes in federal law provided to ensure American Indian and Alaska Native populations participate fairly in these resources, e.g. Medicaid, Medicare, Veterans Administration, Children's Health Insurance program.

- **Adherence to Consultation Policy:** On April 29, 1994, the President issued a Memorandum titled, "Government-to-Government Relationship with Native American Tribal Governments", to heads of executive departments and agencies. It reaffirmed the unique relationship between the U.S. Government and Native

American Tribal Governments as stated in the Constitution, treaties, statutes and court decisions. It directed each executive department and agency to consult with tribal governments prior to taking actions that affect them. On August 7, 1997, The Secretary of HHS, Donna E. Shalala issued a Memorandum entitled, "Department Policy on Consultation with American Indian/Alaska Native Tribes and Indian Organizations", transmitting the HHS tribal consultation policy to Heads of HHS Operating Divisions and Staff Divisions. Further, the memorandum directed each Operating Division to develop a policy on tribal consultation for their agency. Throughout the Roundtable, participants encouraged that the I/T/Us use the HHS consultation policy in their activities and in the reauthorization process. A copy of the policy is in the Appendix of this report.

IV. BRIEF OVERVIEW OF PUBLIC LAW 94-437, THE INDIAN HEALTH CARE IMPROVEMENT ACT (IHCIA)

On September 30, 1976, the President signed Public Law 94-437, the Indian Health Care Improvement Act (IHCIA). The goal of this Act is to ***"provide the quantity and quality of health services necessary to elevate the health status of American Indian and Alaska Natives to the highest possible level and to encourage the maximum participation of tribes in the*** *planning* ***and management of these services."*** The Act contains numerous program authorities along with specific health status objectives that were to be achieved for American Indians and Alaska Natives in the United States. In summary, the Indian Health Care Improvement Act includes the following Titles and Programs:

- **Declaration of Health Objectives –** Enumerates **61** specific health measurements or objectives, which are to be met by the Indian Health Service by the year 2000.

- **Title I – Indian Health Manpower.** Several health professions programs are included such as Health Professions Recruitment; Health Professions Preparatory Scholarships; Indian Health Professions Scholarships; the Extern Program; Continuing Education Allowances; Community Health Representative (CHR) Program; IHS Loan Repayment Program; Scholarship and Loan Repayment Recovery Fund; Recruitment Activities; Tribal Recruitment and Retention Program; Advanced Training and Research; Nursing Program; Nursing School Clinics; Tribal Culture and History; INMED Program; Health Training Programs of Community Colleges; Additional Incentives for Health Professionals; Retention Bonus; Nurse Residency Program; Community Health Aide Program for Alaska; Matching Grants to Tribes for Scholarship Programs; Tribal Health Program Administration; University of South Dakota Pilot Program.

- **Title II – Health Services.** Intended to improve service delivery, this title includes the following programs: Indian Health Care Improvement Fund; Catastrophic Health Emergency Fund; Health Promotion and Disease Prevention Services; Diabetes

Prevention, Treatment and Control; Hospice Care Feasibility Study; Reimbursement from Certain Third Parties for Costs of Health Services; Crediting Reimbursements; Health Services Research; Mental Health Prevention and Treatment Services; Managed Care Feasibility Study; California Contract Health Service Demonstration Program; Mammography Screening Coverage; Patient Travel Costs; Epidemiology Centers; Comprehensive School Health Education Programs; Indian Youth Grant Program; American Indians Into Psychology Program; Prevention, Control, and Elimination of Tuberculosis; Contract Health Service Payment Study; Prompt Action on Payment of Claims; Demonstration of Electronic Claims Processing; :Liability for Payment; and Office of Indian Women's Health Care.

- **Title III – Health Facilities.** Numerous health facilities, sanitation construction projects were impacted by the provisions of this title. Programs covered under Title III include: Consuhation, Closure of Facilities; Safe Water and Sanitary Waste Disposal Facilities; Preference to Indians and Indian Firms; Soboba Sanitation Facilities; Expenditure of Non-Service Funds for Renovation; Grants for Construction, Expansion, and Modernization of Small Ambulatory Care Facilities; Indian Health Care Delivery Demonstration Project, Land Transfers; and Applicability of Buy American Requirement.

- **Title IV – Access to Health Services.** Provisions for the billing of Medicare and Medicaid are included in this title. Programs in Title IV include: Treatment of Payment Under Medicare Program; Treatment of Payments Under Medicaid Program; Reports Required; Grants to and Contracts with Tribal Organizations; Demonstration Program for Direct Billing of Medicare, Medicaid and other Third Party Payors; and Authorization for Emergency Contract Health Services.

- **Title V – Health Services for Urban Indians. This** Title provides authority for services to urban Indian populations. Programs include: Purpose Statement; Contracts With and Grants To Urban Indian Organizations; Contracts and Grants for the Provision of Health Care and Referral Services; Contracts and Grams for the Determination of Unmet Health Care Needs; Evaluations and Renewals; Other Contract and Grant Requirements; Reports and Records; Limitation on Contract Authority; Facilities Renovation; Urban Health Programs Branch Grants for Alcohol and Substance Abuse Related Services; Treatment of Certain Demonstration Projects; and Urban NIAAA Transferred Programs.

- **Title VI – Organization@ Improvements. This** title includes: Establishment of the Indian Health Services as an Agency **of the** Public Health Service; and Automated Management Information System.

- **Title VII – Substance Abuse Programs.** Title VII includes: Definition of MS Responsibilities; MS Programs; Indian Women Treatment Program; IHS Youth Program; Training and Community Education; Gallup ASA Treatment Center;

Reporting Requirements; Fetal Alcohol Syndrome and Fetal Alcohol Effect Grants; Pueblo Substance Abuse Treatment Project for San Juan Pueblo, NM; Thunderchild Treatment Center; Substance Abuse Counselor Education Demonstration Project; Gila River Alcohol and Substance Abuse Treatment Facility; Alaska Native Drug and Alcohol Abuse Demonstration Project;

- **Title VIII – Miscellaneous. This** Title includes: Reports; Leases with Indian Tribes; Availability of Funds; Limitation of Use of Funds Appropriated to the MS; Nuclear Resource Development Health Hazards; Arizona as Contract Health Service Delivery Area; Eligibility of California Indians; California as a Contract Health Service Delivery Area; Contract Health Facilities; National Health Service Corps; Health Services for Ineligible Persons; Infant and Maternal Mortality and Fetal Alcohol Syndrome; Contract Health Services for the Trenton Service Area; IHS and VA Health Facilities and Sharing of Services; Reallocation of Base Resources; Demonstration Project for Tribal Management of Health Care Services; Child Sexual Abuse Treatment Programs; Tribal Leasing; Home and Community-Based Care Demonstration Project; Shared Services Demonstration Project; Results of Demonstration Projects; and Priority of Indian Reservations.

V. ROUNDTABLE FINDINGS AND RECOMMENDATIONS

The focus of the Roundtable was the reauthorization of the Indian Health Care Improvement Act (IHCIA), Public Law 94-437. The upcoming reauthorization of the Act provides opportunities for the I/T/Us to be proactive in updating the Act by incorporating provisions related to the current health care environment and other issues pertinent and relevant to I/T/U programs. The participants were asked to think globally and futuristically about the Indian health care environment.

To gain a global perspective of the Act and the areas it impacts, the Roundtable participants, by group consensus, chose to remain in a large group to share open discussions on issues related to the Act and relevant to the current environment of health care delivery and services impacting I/T/U systems. Following large group discussions, two umbrella topics were identified: **"Patient Bill of Bights for Indian People"** and **"Changing Health Care Environment."** Participants then formed a Workgroup for each topic. Each Workgroup brainstormed major concepts or themes and looked at what is needed to support all activities and service delivery systems of the J/T/U. This would include discussing viewpoints, perspectives, impacts, effects, relationships, creative and futuristic thinking, long-term and short-term elements. Following these intense discussions, each Workgroup identified underlying themes that resulted from their discussions of various issues and then listed the issues.

Each Workgroup presented their recommendations through a designated spokesperson to the whole group of Roundtable participants for discussion. The discussion of the topics,

themes and issues resulted in a base of information to begin consultation with leadership of tribes and urban Indian health programs for their input on the content of the reauthorization legislation so that their views are reflected.

A. "Patient Bill of Rights for Indian People"

Purpose: To examine the feasibility of establishing a guaranteed level of health care benefits, including emphasis on prevention for all American Indian and Alaska Native beneficiaries of the I/T/U system. Minimally, no less than Medicaid covered services; also see FQHC/RHC funded services in Federal statutes. To be successful, this effort would require a definition of the "standard services" or guaranteed package of benefits, which are available. Second, these services must be articulated to the beneficiaries, so that there is adequate understanding from the users of the I/T/U system. Finally, a mechanism for the continual monitoring and evaluation of services should be in place, so that services could improve based upon the needs and input of patients, not the shortcomings of federal budgets.

1. Political Environment

- The basic rights and needs of American Indians and Alaska Native for health services have been overshadowed in the political environment. A Patient's Bill of Rights must ensure that Congress, the Administration and those charged with administering the trust responsibilities of the federal government are cognizant of the impact cuts to the I/T/u system have on the health care of Indian families. The political and legislative process needs to be more responsive to situation of Indian health systems.
- The reauthorization process should avoid legislating internal operational procedures and requirements in the law. The new Act should stand the test of time, provide fundamental policy and mandates regarding the protection and enhancement of Indian health, and avoid operational issues.
- American Indian and Alaska Native leaders should examine which programs have been successful in realizing substantial budget increases, such as the National Institutes of Health (NIH), AIDS Research, women's health, immunization initiatives, child health insurance, and which have been losers, such as the MS budget. Examine the reasons why some health issues prevail in the political process and others do not.
- Consider transferring the duties for appropriating funds for Indian Health Service out of the Interior Appropriations Subcommittee and into the Labor, Health and Human Services Appropriations Subcommittee, which handles all other health, related appropriations. Under this scenario, the MS would be balanced against other federal health programs in the allocation of funds,

instead of shifting funds from BIA or other Interior Department programs to restore IHS budget cuts. Also, need collaboration with Senate Finance committee and House Energy and Commerce Health Sub-Committee to get at Medicaid policy and legislative initiatives.

- Within the Department of Health and Human Services, examine the role of Public Affairs Office in addition to the Management and Budget Office, when educating federal officials about the needs of Indian patients and the need for appropriate funding for the I/T/U systems.
- Balance of power has been shifted to states in area of health care, particularly with regard to Medicaid related programs. Indian patients have a right as dual citizens to access alternate resources, and the I/T/U budget have come to depend upon third party revenues. More attention should be given to protecting Indian patient rights under state administered systems.

2. **Refocus Act on Prevention and Other Issues**

- Indian and Alaska Native patients have a right to have high quality and comprehensive prevention services available through their community I/T/U system. A shift in focus in the IHCIA toward preventive measures is appropriate given the types of health problems experienced by native populations.
- Access to more comprehensive health care is a right of American Indian and Alaska Native patients. An effort to balance the scope of services across the board should be a priority.
- Elderly patient care should be evaluated to ensure high quality and appropriate scope of services is provided. The changing nature of health problems experienced by Indian elderly, might suggest new strategies and more community-based intervention.
- Identify why the Act is currently not working, that is which programs work and which do not. Assess how it can be re-designed to give both tribal and urban access to contracting under self-determination.
- Focus IHCIA priorities on meeting needs of the patient base. The unmet health needs of American Indian and Alaska Native communities should dictate the priorities of the new legislation. Quality of care from the perspective of the patient should be considered.

3. **Public Health Infrastructure**

- The provision of basic public health functions under the umbrella of the Indian Health Service has been a major benefit to the elevation of Indian health status through environmental improvements. Preservation of the public health infrastructure within the context of increased tribal self-determination contracting and self-governance compacting is important to consider, and if necessary ensure adequate legislative provisions for the public health and environmental safety of Indian communities to continue.

4. Community Ownership of Health Care Delivery Systems

- **Innovative, community-based strategies** for the development of comprehensive health services should be fostered and expanded under the IHCIA. An assessment and development of innovative strategies should be conducted for consideration of how I/T/U systems could better organize and manage their health services in a competitive managed care environment.

5. Urban Programs

- **Allow** for expanded considerations of the relationship of urban health programs under the I/T/U structure, and how urban programs relate to the Indian Self-Determination Act. The rights of patients residing in urban areas should be considered. They are still enrolled tribal members and there should be some re-assessment of eligibility and funding for services that respects the rights of urban patients.

6. Managed Care

- **Over 80%** of Americans now receive their health services through some sort of "managed care organization". States have adopted managed care organizations as the system through which state health programs, such as Medicaid are administered. The **I/T/U** system is becoming more and more dependent upon the third party **payor** to cover-increased costs. The IHCIA reauthorization process should include some assessment of managed care on Indii patient rights, and whether our I/T/U system is adequately prepared to compete in a managed care system. Medicare and Medicaid should be first **payor** for Indians who are eligible and tribes should be able to set up their own health maintenance organizations or Congress should give MS Medicare and Medicaid money directly to IHS to administer.

8. Partnering - Federal, State, Tribal Governments and I/T/U System

- The provision of health services to Indian patients goes beyond the scope of MS resources. The IHCIA should include an assessment of all federal, state and local resources, which combine to assist Indian patients. Legislation which will improve the position of **I/T/U's** to negotiate benefits for Indian and Alaska **Native patients is recommended. Agencies, such as the Health Care Financing** Administration play major roles in the effort to improve Indian health. Federal legislation should be considered to eliminate roadblocks experienced in many of these agencies.
- The task of elevating Indian health status goes beyond the provision **of just** clinical services. Other social issues and factors include family violence,

substance abuse, injury issues, lack of viable economic development ventures, etc. The IHCIA should expand the resources available to I/T/U's to intervene in the psychosocial or behavioral health areas.

9. **Tribal Self-Determination and Self-Governance**

- There should not be penalties for those tribes opting to contract, compact or receive services through the Indian Health Service. Provisions should be considered which will ensure equity for all partners in the I/T/U system, regardless of which administrative mechanism each chooses. The basic rights of Indian and Alaska Native patients to health care, should not be dramatically affected by the contracting methods employed to deliver services.

10. Cost Factors

- The I/T/U system is on the losing end of virtually all health care financing systems currently being applied. The Balanced Budget Agreement has eliminated any hope that the I/T/U's will receive needed increases to keep pace with inflation and population growth. Federal administrative initiatives, such as "Reinventing Government" and GPRA further threaten the MS structure within the Public Health Service. Welfare Reform has increased the demand on the I/T/U mental health and alcohol services, without proportionate increases in resources. Welfare Reform has also triggered a drop in Medicaid enrollments in each state, depleting I/T/U anticipated revenues. The financing systems are driving a reduction in services to American Indian and Alaska Native patients. Our patients should have an "entitlement" to health services, as do Medicaid and Medicare patients. Maybe consider MS money as an entitlement; this would create major changes organizationally and politically that would need to be analyzed beforehand.

11. Other Factors

- Federal Tort Claims Act coverage under the I/T/U system should be evaluated to ensure it is adequately covering all providers and ensuring the protection of patient's right to access high quality care and due process for patient claims. FTCA coverage should be extended to urban providers under the I/T/U.
- The formal consultation policy developed by Secretary Donna Shalala (DHHS) should be included in the regional consultation meetings pertaining to the reauthorization of the Indian Health Care Improvement Act.
- Elevation of IHS Director within DHHS to an Assistant Secretary position is absolutely critical to ensure the rights of our patients are protected at the highest levels of budget deliberation.

B. "Changing Health Care Environment"

Purpose: These recommendations are designed to identify key changes in our health care environment, including public health and clinical services; and identify key health care delivery issues related to Urban Indians. These recommendations address issues related to our "entitlement" to health services; the ability of our patients to access basic services within the I/T/U network; and financial barriers and proposed solutions to improve the financing of J/T/U systems.

1. Facilities

- New and innovative facility construction financing options should be examined for inclusion in the reauthorization of the IHCIA. There may be different approaches for the different problems to address tribal and urban facility needs. Consider establishing a capital loan or guaranty program with emphasis on ambulatory care facilities. Consider balanced, fair approach to fund all types of facilities construction, so majority of money doesn't go to just one type of facility.
- Include Joint Venture Demonstration projects as a permanent part of the IHCIA, which will allow tribes and urban programs to fund the expansion or replacement of their facilities and be ensured adequate staffing and equipment through the MS, as partners in the overall system.

2. Health Care and Manpower Issues

- The IHCIA should exempt all direct health care providers from any restrictions on Full-Time Equivalent ceilings imposed by the Administration or through federal law.
- The IHCIA should include a Mentor Program to assist Indians going through health professional programs, include leadership training.
- Remove impediments from current legislation on how the loan repayment program money is being allocated; let it be driven more by where manpower needs really are.

3. Political Strategy for Indian Access to Other Funding Programs

- Need to develop political strategy to access other funding programs such as those available through Health Services and Resources Administration and being tapped into for Historically Black Colleges and Universities (HBCU). Tap into those resources for Indian tribal colleges to create opportunities and incentives

4. Billing, Reimbursement and Financing

- Health care providers and I/T/Us should have the authority to receive reimbursements directly from the Health Care Financing Administration (HFCA), by-passing the States. Search out successful demonstrations that have occurred and consider new an innovative legislation to bring I/T/U's on a level playing field with states in regards to Medicaid administration.
- Include amendments to IHCIA to allow MS or tribal Self-Determination Act contractors to bill tribal employee insurance programs and self-insurance programs, if authorized by the tribal government. Eliminate or amend the current prohibition in the IHCIA against big tribal self-insurance programs.
- Permit I/T/U's to bill each other for services provided to Indians from other I/T/U systems, after bii third party payors.
- Exempt tribes and Indians from costs of premiums they are currently required to pay in Children's Health Insurance Program (C.H.I.P.), Medicare -Part B., etc. Our right to health care has already been pre-paid.
- Tribe must receive full Contract Support Costs in compliance with amendments to the Indian Self-Determination Act, when contracting and taking over the administration of IHS services. The inability of Congress to keep pace with CSC, is creating a depletion in overall resources for delivery of services to American Indians and Alaska Natives. The problem of funding for CSC expenses must be dealt with in the IHCIA.

5. Urban Issues

- Urban Indian providers have not been provided full opportunity for consultation; Urban Indians should not lose their right to be a part of consultation when they leave the reservation.
- Clarify the rights and benefits of urban patients and urban health providers under the new IHCIA. Urban Indian populations should be included in the allocation formula of the Indian Health Service to ensure adequate funding for all Indian and Alaska Native people, regardless of residence. Urban programs should receive funding based upon user populations and be able to provide the full range of services to patients.
- Expand and make permanent the two urban demonstration projects in Oklahoma. These projects have proven that urban providers can be merged into the overall I/T/U system successfully.
- Amend the Federal Tort Claims Act to include FTCA coverage for urban contractors under Title V of the IHCIA, just as the IHS and tribal contractors are now covered.

6. Access To Health Care

- The allocation of health care services and resources should be based upon tribal enrollment and not geographical location. Contract Health Service Delivery Area (CHSDA) should follow the individual regardless of residence. Access to I/T/U services should be an "entitlement" for enrolled Indian and Alaska Native people. The eligibility criteria is too vague and needs to be more clearly defined.
- Third Party, Medicaid/Medicare, and CHIP eligibiity mechanism needs to be strengthened, including I/T/U authority for on-site eligibiity determinations. Amendments to federal law beyond IHCIA should be examined to achieve better access by I/T/U patients to Medicaid and Medicare.
- Language and authority is recommended to allow the I/T/Us to purchase health care and health care insurance and to provide it under the Indian Health Service system.
- Third-party collections should not be used to offset MS budget. There should be a legal prohibition against offsetting the MS budget with projections of third party revenues.
- Need specific language for access of I/T/U's to all special initiative funds such as the Tobacco Settlement legislation, which should include direct access for I/T/U's, bypassing States.

7. Managed Care

- Federal law should be amended to provide for a direct set-aside at the national level for all Medicaid and Medicare payments to I/T/U's to be centrally administered through the MS for the benefit of I/T/U's and their Indian and Alaska Native patients. I/T/U's should not be forced to negotiate with states or state contractors for reimbursement of services.
- Short of a direct set-aside, Federal law should be amended so that states are required to contract with I/T/U's for the provision of health care to Indian Medicaid beneficiaries who are patients of the I/T/U system. It should not be allowable under federal law to have Indian patients arbitrarily assigned to other managed care providers of the state, and I/T/U's suffer a loss in revenues. In most cases, Indian patients continue to utilize the I/T/U, but their Medicaid reimbursement is lost due to arbitrary assignments to other MCO's.
- Freestanding I/T/U clinics, should be able to bill Medicare-Part B.
- Legislation is need to allow I/T/U's to assume risk and have their own managed care plans, including the need to amend the Anti-Deficiency Act to eliminate impediments that keeps I/T/U's from taking on these capitated, managed care ventures.
- Tribes need investment risk capital for developmental money reserves to take on risk.

- Adjustment on capitation rates for I/T/U's should be provided in federal law to ensure that even under a capitated system, the I/T/U's are more likely to receive 100% reimbursement for high-risk populations.
- Change Urban and tribal outpatient programs FQHC right to reasonable costs in Medicare/Medicaid and eliiate barriers.

8. Prevention and Public Health Care Services

- The IHCIA should provide that I/T/U's have access to all Federal program services and funds under Public Health Service. If funds are available to States, they should be made available to I/T/U's.
- Access and coordination with other services by other departments and programs to better utilize available resources, i.e., Veterans Administration, etc. should be included in the IHCIA reauthorization.
- Departments and agencies of the federal government should be required accountability to I/T/Us for funds they received that address Indian health care issues, i.e., research funds, Center for Disease Control, etc.

9. Data and Technology

- Legislative language needs to specifically instruct and require the Public Health Service (PHS) to collect more comprehensive data and statistics on American Indians and Alaska Natives. Need to have a comprehensive assessment of what is going on in Indian Country. Currently, there is concern over accuracy and scope of available PHS data. IHS (RPMS), tribal and urban systems collect diierent types of data; need national data set and repository; need common indicators. I/T/Us should have access to Center for Disease Control (CDC) data systems
- Legislative language should include access to new technology as it becomes available to enable I/T/U's to provide better and more comprehensive health care services.

10. Long-Term Health Care

- Explore long-term demonstration projects to provide national and legislative authority for tribes to have flexibility, i.e., provision for home and community-based care and other long-term services. Would enable Tribe to identify what their most important needs are.

C. Recommendations Concerning the Consultation Process

The Roundtable participants felt the manner in which the tribal consultation meetings are conducted and carried out will be critical to successfully gaining the support for the

reauthorization of the IHCIA. The participants also felt all the stakeholders (I/T/U's) need to participate and be well informed and oriented to what is involved in the reauthorization process, as well as those who are part of the process in the Department, OMB, and in Congress. Changes have occurred in the health care environment at the State and national levels; in the I/T/U health care delivery systems; in Congress and at the Department of Health and Human Services. This has created a void in knowledge and support for Indian health, that will be critical to the reauthorization of the Act. It is essential that everyone be informed and oriented to the meaning and importance of the Indian Health Care Improvement Act. Participants shared the following comments that have been grouped into these topics:

1. Agenda

- Use a roving core group at the consultation meetings to elaborate on points made at the Roundtable. Use this same core group to work with OMB and Congress.
- Have a forum for urban providers; identify where they can be supportive.
- Need to develop the agenda well; we have an ambitious agenda and our political clout needs to be strengthened.
- Identify specific products of the meeting.
- Implementation and follow-through important; share with the chairpersons and tribes; let tribes help shape the Act; keep tribes informed.
- Target achievable goals in the reauthorization process.
- Identity "budget neutral" issues; significant barriers, committees.
- Keep lines of communications open; even if there is a dissenting vote;

2. Asking for and Developing Support

- Say, "we need you"; this is important legislation;
- Communicate with the White House; involve the First Lady
- Elevation of the IHS Director to Assistant Secretary level should assist in the Reauthorization process.
- Invite support groups to attend the Regional consultation meetings; include Friends of Indian Health on a regional basis.
- Identify all the groups that can support Reauthorization, i.e. Self-Governance tribes and Advisory Committee, 638 contractors, Chairpersons, organizations, groups, etc.
- Involve the Domestic Policy Council as a pathway to the White House.
- Expand the presence and use of health boards, organized groups, advisory boards, etc., and keep them in the loop.
- Don't forget other departments, specialized services, Department of Defense and other partnerships, American Public Health Association, foundations, etc.

3. **Atmosphere & Setting of the Consultation Meetings**

- Make tribal leaders feel welcome
- Seating arrangements important-sit together, same level if possible

- Keep meetings positive; keep communications open.
- Use personal touch during meetings.
- Need to be very cognizant of government-to-government relationships.
- Should promote a "partnership" environment for I/T/U's

4. Considerations for Content of the Act

- Grasp complexities of the act -- try to improve quality and access to health care in the new one.
- This is the time to include AI/AN in the recent evolution that has occurred in health care; people are ready to rewrite programs; and states looking for fresh approach to Medicaid and tribes
- Information used in the last re-authorization should be updated - charts/financial and data studies, and actuarial work.
- Identify strengths and weaknesses of the Act.
- Need to identity standard benefit plan/package for American Indians and Alaska Natives and present measurable data on how funding is being used to provide for quality health care and address needs.
- Identity the fundamental issues of the Act
- Reauthorization is an opportunity to address issues in the Act that are of common concern.
- We are in a new era where Tribal leaders are involved in development of regulations. The consultation process should present ideas for discussion and re-shaping as needed, working toward consensus or the development of diierent models.
- Need to take a whole new look on how we approach the Act, encouraging creativity and new ideas

5. Developing Support for Reauthorization Orientation For all Those in the Reauthorization Process

- Need to educate/orient individuals and offices involved in the reauthorization process to Tribal Consultation, Tribal health care needs, etc.
- Need to develop and shape the reauthorization package with the Office of Management and Budget (OMB) ahead of time to make the approach and process smoother.
- Invite Dr. Satcher to consultation meetings with Dr. Trujillo escorting him.
- Write letters from Chairpersons to HHS officials to familiarize them with tribal needs, issues, and why they need to support the Reauthorization Act; include OMB officials. Also, invite them to the regional meetings or take them on trips to the field
- Discretionary spending is decreasing, the source of IHS funding; need to raise awareness of Deputy Secretary Thurm and the Secretary to the impact and affect on I/T/Us.

- HHS Public Affairs Office has a key role; involve them; they go beyond public affairs.
- Many members of the House of Representatives are new and will be unfamiliar with reauthorization and I/T/Us; they will have not have experience or knowledge of government-to-government relationship of Tribes.
- Need to draw into orientation committees of Congress to make sure they understand Indian Country. Support is no longer among some of the committees (Senate Finance Committee, House Commerce, void in Indian Affairs Subcommittee); need to cultivate new understanding and support for reauthorization.

6. Materials/Information

- Keep it simple
- Use bullets. Keep it simple but reflect complexities.
- Use graphics; visuals work in Indian country.
- Keep materials to a minimum.
- After developing materials for consultation meetings, bounce materials off several chairpersons for feedback.
- Develop a briefing document of the matter or condensed summaries of materials to reduce volume of material.

7. Preliminary Preparations

- Need to get Area Directors up to speed to address questions and go to advisory boards.
- Personally telephone call each chairman in the region of the meeting; keep at it until they are all reached
- Encourage Chairperson to personally attend;
- Stress their importance in developing a partnership to.support Reauthorization
- Address correspondence to Tribal leaders individually, as persons and heads of states, in correspondence; eliminate the 'Dear Tribal Leader" letter.
- Do pre-press work
- Use the same method as used with budget formulation process
- Give ample notice of meetings
- Use Chairpersons to help present at the meetings
- Keep HHS Public Affairs Office informed; they sometimes influence and shape issues.

8. Regional/Tribal Differences

- Identify regional/tribal differences ahead of time so they can be addressed
- Identify regional/tribal issues ahead of time so they can be addressed.
- Take time to know peculiarities of each area, i.e. Alaska people fish entire month of July, therefore, no one available to meet during that period until August.

9. Tribal Consultation Process

- Consultation process needs to be identified bringing in all I/T/U's into full focus, clarifying that we are all on equal playing field; reauthorization is not a competition for funds.
- Whatever the consultation process yields, Chairpersons should be part of the working groups to develop a more detailed process of what will go into the bill.
- Always have issues on the table--like them or not, good or bad; and then develop national plan
- Identii and communicate timeframes of the process
- Implementation and follow-through important; share with the Chairpersons, tribes, and urban providers
- Use a core group to review materials for reauthorization; core group to be part of roving core at consultation meetings to elaborate on points made at the Roundtable. Use Core group to work with OMB and Congress.
- Need to specifically involve the Senate Committee on Indian Affairs, Senate Finance Committee and House Resources Committee.
- Need to arrive at a framework that has consensus from the affected communities
- Need to take a broad approach with the help of experts in the field and community leaders.
- Need a clear explanation and communication with tribal leadership of the budget "neutrality" aspects of this legislation
- Congress will ask, where is the money going that we have already given? Be prepared with answers and responses.
- Take a whole new look at all health packages; use creativity.
- Reauthorization should be for 8 years to be consistent with other acts.
- The National Medical Expenditures report needs to be updated.

10. Urbans

- Involve Urban Indian health providers in the process;
- 34 metropolitan centers are ready to make contacts to support reauthorization, and have been very effective in all prior Indian health amendments.

It is important for all participants in the consultation process to understand that the MS is required to follow certain internal federal procedures in the preparation of legislation, in addition to the consultation process itself A series of consultation meetings will be conducted throughout the year with the IHS and the Department of Health and Human Services. Following this consultation process, a legislative proposal must be submitted to the Office of Management and Budget (OMB). A series of questions will be raised and discussions held with MS and legislative staff The DHHS Tribal Consultation policy should be reinforced throughout this process.

The proposal will next be forwarded to the Office of General Counsel (OGC) within the DHHS to be developed as legislation. When it goes from MS to them, they will want to know how much is it going to cost and will conduct their own assessment in addition to what IHS and the tribes submit to them. DHHS will draft the specific legislative language based on the A-19 process including the financial and staging impacts. Finally, the legislation will be included as part of the Administration's request to the President in the annual budget process.

VI. CLOSING REMARKS

Dr. Michael H. Trujillo, Director of Indian Health Service, provided closing remarks. He said he would be updating the Deputy Secretary of HHS regarding the activities and outcomes of the Roundtable. He felt the Roundtable was a good, productive brainstorming session.

Regarding the legislation he stated it should continue to reflect and address I/T/U issues and be adapted to the changing national health care environment. Each title needs to be reviewed and reassessed for appropriateness and we need to have accountability in the I/T/U programs, Continuing struggles with the budget and changes in the Administration in the Department and in Congress present different challenges and opportunities relative to how to approach the legislation. The reauthorization process itself is cumbersome and complicated and a strategy needs to be developed to move the legislation along.

Regarding the tribal consultation process, Dr. Trujillo suggested we assess the results of each meeting and evaluate the process for improvement as it is implemented. A number of products will be developed as a result of the regional consultation meetings which will need to be tracked. We will need a team to manage the process and take charge of tasks and logistics, especially after the passage of legislation. They will need to identify strategic points of time, assess other parallel legislation, and dates for development of products to ensure accomplishment of tasks, specific dates, and identify deadlines.

Dr. Trujillo expressed his appreciation to all the Roundtable participants for their participation and contributions to the meeting. He plans to stay involved with them throughout the consultation meetings and reauthorization process. He felt the I/T/U's have the initiative and ingenuity to accomplish the goals of the reauthorization legislation and believes the focus of our effort should reflect us ***"speaking with one voice".***

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APPENDICES

- **The Roundtable Agenda**
- **The Roundtable Participants List**
- **The Roundtable Briefmg Document - Roundtable on the Reauthorization of Public Law 94-437, the Indian Health Care Improvement Act (IHCIA)**
- **A Legislative Update - May 12, 1998**
- **Key Facts on Indian Health Programs**
- **HHH Tribal Consultation Policy, Dated August 7, 1997**

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An Indian Health Service Roundtable to Discuss

*THE **REAUTHORIZATION** OF THE **INDIAN HEALTH** CARE **IMPROVEMENT ACT (IHCIA)** PUBLIC LA W 94-437*

AGENDA

Monday, June 8.1998;

7:30 a.m.	Continental Breakfast and Registration
8:00 a.m.	Welcome Blessing Introductions: Facilitator, Participants, Others Opening Remarks - Dr. Michael H. **Trujillo,** M.D., M.P.H., **M.S.** **Assistant** Surgeon General Director, Indian Health Service Purpose - Michael **Mahsetky** Director, Congressional **&** Legislative **Affairs,** MS
10:00 a.m.	Break
10:15 a.m.	Work Croup Discussions
12:OO p.m.	Working Lunch - Conference Room **"M"**
1:00 p.m	Reporting Out By Croups
2:15 p.m.	Break
2:30 p.m.	Croup Discussions
3:30	Where Are We? Next Steps?
5:00 p.m.	Adjournment

Tuesday, June 9, 1998;

7:30 p.m.	Continental **Breakfast**
8:00 a.m.	Welcome Introductions Announcements
8:30 am.	Concluding Recommendations **&** Discussions
9:00 am.	Reauthorization Process - Michael Mahsetky Director, Congressional & Legislative **Affairs, IHS**
9:45 am.	Tribal Leaders Presentations/Responses
11:15 am.	Closing Remarks - Dr. Michael H. **Trujillo,** M.D., M.P.H., M.S. Assistant Surgeon **General** Director, Indian Health Service
1:00 p.m.	Adjournment

*An Indian **Health** Service **Roundtable** to **Discuss***
THE REAUTHORIZATION OF
THE INDIAN HEALTH CARE IMPROVEMENT ACT
INDIAN HEALTH SERVICE *JUNE 8-9, 1998 * ROCKVILLE, MARYLAND

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Briefing Document

Roundtable On The Reauthorization of P. L. 94-437, The Indian Health care Improvement Act

June 8-9, 1998
Rockville, Maryland

Indian Health Service
U. S. Public Health Service
Rockville, Maryland 20857

Briefing Document

Roundtable On the Reauthorization of P.L. 94-437, The Indian Health Care Improvement Act (IHCIA)

Indian Health Service
Rockville, Maryland
June 8- 9, 1998

INTRODUCTION

This briefing document is divided into three areas beginning with the purpose of the Roundtable, moving on to the goals, and at the end gives background information on the history of the Indian Health Care Improvement Act (IHCIA) and an overview of the government to government relationship between the federal government and Indian Tribes.

PURPOSE

The IHCIA is the cornerstone for the MS in the provision of health care services to Indian people. The authority for the Act expires in fiscal year 2000. The Roundtable will explore through discussion and dialogue the changing health care environment that is occurring throughout the nation and how these changes impact on the ability of tribal, urban Indian health programs, and the IHS to deliver quality health care. In the years since enactment of the IHCIA, many changes have occurred in the health care environment, including changes in the welfare and Medcaid programs. States have instituted a variety of health care reform measures through the use of Medicaid waivers granted by the Health Care Finance Administration (HCFA). The implementation of Medicaid waivers has directly impacted on the ability of tribal health programs to maximize their Medicaid reimbursements and to participate in full partnership with states. For instance, many times tribal health facilities are not considered for inclusion in the state plan and as a result Indian participants are required to enroll for their health care in non-tribal health programs. This directly impacts on the ability of tribes to maximize Medicaid, Medicare and third-party reimbursements. As efforts to maintain a balanced federal budget continue, the level of congressional appropriations for Indian health care continues to decline and reliance on these third-party revenues continues to increase.

In addition, increases in contracting and compacting pursuant to the Indian Self-Determination Act require new strategies and relationships between tribes and the IHS. Reauthorization of the IHCIA should reflect the spirit and intent of the Indian Self-Determination Act.

Goals

The goals of the Roundtable will include the following:

- Examine the feasibility of establishing a level of health care benefits
- **Identify** key health care delivery **issues** in a changing health care environment including public and clinical health services in Indian communities.
- **Identify** key health care delivery issues related to Urban Indians
- Develop mechanisms and strategies to use in formulation of an approach for consultation with tribes and urban Indian health programs so that their views are reflected in the reauthorization legislation.

The Roundtable will produce a report that will be used to stimulate discussion as the IHS consults with tribes in regional consultation meetings later this summer and early fall.

Participants of this Roundtable have been selected from various backgrounds and include **direct** health care providers, administrators, technical advisors, triial and urban Indian health care leaders, and advocates for Indian health care. The results of this meeting'will be shared with Tribes and urban community members for their information and use in the regional consultation meetings on the reauthorization of the Act.

The Roundtable will explore through discussion the. changing health care environment throughout the nation, and how these changes have impacted and will impact on the ability of tribes, urban Indian health programs and the MS to delivery quality health care services to Indian people. The participants to the Roundtable will help identify key Indian Health care issues that may need to be considered during the reauthorization process. This information will in turn be used to stimulate discussion with **tribes** and urban Indian health care leaders as the MS engages in consultation with these groups later this summer and fall.

With the changes in the health care **environment, the contracting and compacting of MS finding services through Public Law 93-638; state managed care initiatives, welfare reform and other changes in the health care arena, appropriate mechanisms and strategies must be assessed in discussions related to reauthorization of the Indian Health Care Improvement Act.**

BACKGROUND INFORMATION

History of the Health Care Improvement Act

On September **30,** 1976, the **President signed into law the Indian Health Care Improvement Act (Public Law 94-437). The Act has** been amended several times since its enactment. The most comprehensive amendments occurred during reauthorization in 1988. At that time, numerous program authorities were added to the Act, along with specific health goals that were to be achieved. The goal of this Act is "to provide the quantity and quality of health **services** necessary to elevate the health status of American Indian and Alaska Natives to the highest possible level and to encourage the maximum participation of tribes in the planning and management of these services."
This Act is considered the cornerstone of the **IHS** program.

The Indian Health Service is the agency within the Department of Health and Human Services that is responsible for providing federal health services to American Indian and Alaska Natives. The Indian Health Care Improvement Act allows for the appropriation of funding for every aspect of health care services provided to and for American Indians in the United States at the local, area and national levels. The annual appropriation is approximately $2.2 billion.

Currently **558** Tribes are identified in the United States. During fiscal year 1997, the MS appropriations has enable approximately 1.5 million of the nations two million American Indians and Alaska Natives to receive health care services. The median age for Indians in the reservations states (34) is 22.6 compared to 30.0 for the general population. The Indian Health Service population reflects these trends with 32 percent of patients served under the age of 15 and the service population growing at the rate of 2.7 percent per year.

The 1998 Indian Health Services objectives include, but are not limited to:

(1) "Assist Indian tribes develop their health program through activities such as health management training, technical assistance and human resources development.

(2) Facilitates and assists Indian tribes to coordinate health plating, in obtaining and using health resources available through federal, state and local programs and in operating comprehensive health care services in health program evaluations.

(3) Provides comprehensive health care services, including hospital and ambulatory medical care, preventive and rehabilitative services, and development of community sanitation facilities; and

(4) Serves as the principal federal advocate for Indian in the health field to ensure Comprehensive health services for American Indian and Alaska Native people."

Consultation and Coordination with Indian Tribal Governments

The government to government relationship between the federal government and Indian Tribes was established in 1887 and is based on Article 1, Section 8, of the United States Constitution, and has been given form and substance by numerous treaties, statues, executive orders, and court decisions. Just last month President Clinton signed an Executive Order, which re **affirms** consultation with Tribes.

President Clinton stated on May **14, 1998, "Since the formation of the** Union, the **United** States has recognized Indian tribes as domestic dependent nations under its protection. In treaties, our Nation has guaranteed the right of Indian tribes to self-government. As domestic dependent nations, Indian tribes exercise inherent sovereign powers over their members and territory. The United States continues to work with Indian tribes on a government-to-government basis to address issues concerning Indian tribal **self-** government, trust resources, and Indian tribal treaty and other rights.

Therefore, by the authority vested in me as President, by the Constitution and laws of the United States of American, and in order to establish regular and meaningful consultation and collaboration with Indian tribal government in the development of regulatory practices on Federal matters that significantly or uniquely **affect** their communities: to reduce the **imposition** of unfounded mandates upon Indian **tribal** governments; and to streamline application process for and increase the availability of waivers to Indian to Indian tribal government.. .."

In summary, the Roundtable is an opportunity for participants to contribute to the reauthorization of the Indian Health Care Improvement Act in a significant way. Your expertise in the field of health care will contribute to a successful Roundtable, and will establish a basis on which meaningful consultation can occur.

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LEGISLATIVE UPDATE

May 12, 1998

ON MAY 1, THE PRESIDENT SIGNED INTO LAW HR. 3579, THE EMERGENCY SUPPLEMENTAL BILL FOR FISCAL YEAR 1998 (PUBLIC LAW 105-174)

INCLUDES FOR IHS:

- CARRY OVER AUTHORITY FOR IHS WHERE MS ADMINISTERS A DIABETES PROGRAM AUTHORIZED BY THE BBA OF 1997

- $100,000 FOR SUICIDE PREVENTION ON THE STANDING ROCK RESERVATION

- TECHNICAL AMENDMBNTS RELATED TO CONTRACTING IN THE KIC GATEWAY AREA OF ALASKA

- APRIL 28, SENATORS MURKOWSKI, BAUCUS, (TRENT) LOTT INTRODUCED ABILLTO PERMANENTLY AUTHORIZE AND EXPAND THE MEDICARE/MEDICAID DIRECT COLLECTIONS/REIMBURSEMENT DEMONSTRATION PROGRAM UNDER SECTION 405 OF THE INDIAN HEALTH CARE IMPROVEMENT ACT - THIS BILL WOULD EXPAND THIS DEMONSTRATION PROGRAM TO ALL TRIBES -CURRENTLY 4 TRIBES ARE PARTICIPATING IN THIS DEMO PROGRAM. THE AUTHORITY FOR THIS DEMONSTRATION PROGRAM IS DUE TO EXPIRE AT THE END OF THIS FISCAL YEAR.

- MAY 21 -THE SENATE INDIAN AFFAIRS COMMITTEE WILL CONDUCT A HEARING ON UNMET HEALTH NEEDS OF INDIAN PEOPLE - THE COMMITTEE IS WORKING WITH TRIBES, NATIONAL AND REGIONAL INDIAN HEALTH ORGANIZATIONS, AS WELL AS WITH THE FRIENDS OF IHS IN THE PLANNING OF THIS HEARING. IHS WILL PRESENT TESTIMONY AT THIS HEARING. THE SECRETARY HAS ALSO BEEN INVITED

- TOBACCO LEGISLATION- THE BILL THAT IS BEING SUPPORTED BY THE ADMINISTRATION AND THE SENATE IS ABILLREPORTED OUT OF THE SENATE COMMERCE COMMITTEE AND SPONSORED BY THE COMMITTEE'S CHAIRMAN- SENATOR MCCAIN (R-AZ)

  - REGULATORY AND PUBLIC HEALTH PROVISIONS FOR TRIBAL GOVERNMENTS ARE CONTAINED IN THE BILL. WHILE THE

- FOR INJURY OR LOSS OF PROPERTY, PERSONAL INJURY, OR DEATH CAUSED BY THE NBGLIGENT OR WRONGFUL ACT OR OMISSION OF AN INDIAN TRIBE UNDER CIRCUMSTANCES IN WHICH THE INDIAN TRIBE, IF A PRIVATE INDIVIDUAL OR CORPORATION WOULD BE LIABLE TO THE CLAIMANT IN ACCORDANCE WITH THE LAW OF THE STATE WHERE THE ACT OR OMISSION OCCURRED.

TRIBAL IMMUNITY WOULD BE WAIVED TO ENFORCE THESE PROVISIONS

- FURTHER S. 1691 AUTHORIZES CIVIL SUITS AGAINST TRIBES TO BE HEARD IN STATE COURTS ON A CLAIM ARISING WITH THE STATE, INCLUDING CLAIMS ARISING ON AN INDIAN RESERVATION OR INDIAN COUNTRY IN ANY CASE WHERE THE CAUSE OF ACTION ARISES UNDER FEDERAL LAW OR THE LAW OF A STATE OR RELATES TO TORT CLAIMS OR CLAIMS FOR CASES NOT SOUNDING IN TORT THAT INVOLVE ANY CONTRACTMADEBY THE GOVERNMENT BODY OF AN INDIANTRIBE OR ON BEHALF OF AN INDIAN TRIBE.

- PROVISIONS ALSO INCLUDE REQUIREMENT FOR TRIBE OR INDIAN INDIVIDUAL, TRIBAL CORP TO COLLECT AND REMIT TO THE STATE, ANY EXCISE, USE, OR SALES TAX IMPOSED BY THB STATE ON NONMEMBERS OF THE INDIAN TRIBE AS A CONSEQUENCE OF THE PURCHASE OF GOODS OR SERVICES BY THE NONMEMBER FROM THE TRIBE, TRIBAL CORP, OR MEMBER A STATE CAN SUE IN DISTRICT COURT. OF THE U.S. TO ENFORCE THIS PROVISION

- THE BILL AMENDS THE SELF-DETERMINATION ACT TO AUTHORIZE INDIVIDUAL 638 TRIBAL EMPLOYEES TO BE SUED IN DISTRICT OR STATE COURT, RATHER THAN USING THE FEDERAL TORTS CLAIM PROCESS

- H.R. 1833 - LEGISLATION TO MARE S/G PERMANENT FOR IHS - OUTSTANDINGISSUES INCLUDE RULE-MAKING, REASSUMPTION, CONSTRUCTION.

HOUSE RESOURCE COMMITTEE MARRED UP THIS BILL ON MARCH 25
- NO SENATE COMPANION BILL
- SENATE COULD HAVE HEARING ON THEIR OWN BILL OR THE HOUSE BILL INLATEJULY

- THE HOUSE AND SENATE BUDGET COMMITTEES HAVE NOT PASSED THEIR RESPECTIVE BUDGET RESOLUTIONS FOR FISCAL YEAR 1999, DUE TO DIFFERENCES IN LEVELS OF FUNDING AND OTHER ISSUES RELATED TO TAXATION, THE SENATE WILL NOT WALT FOR THE HOUSE TO ACT WHICH

ADMINISTRATION SUPPORTS THE CONCEPTS OF THIS LEGISLATION, THE ADMINISTRATION CONTINUES TO WORK WITH THE SENATE COMMERCE COMMITTEE TO INCLUDE CHANGES THE ADMINISTRATION WLLL SUPPORT. TRIBAL ISSUES INCLUDE:

- REGULATORY JURISDICTION REGARDING SALES, MANUFACTURE, AND DISTRIBUTION OF TOBACCO PRODUCTS ON INDIAN LANDS

- ABILITY TO ACCESS FUNDS DIRECTLY FROM THE TRUST FUND, RATHER THAN THROUGH STATES

- PROVISIONS FOR IHS TO RECEIVE AND ADMINISTER FUNDS FROM TRUST FUND FOR TRIBES WHO DO NOT CHOOSE TO ADMINISTER THEIR OWN PUBLIC HEALTH PROGRAMS

- MAY 6 - THE SENATE INDIAN AFFAIRS COMMITTEE HELD A HEARING ON S. 1691, "THE AMERICAN INDIAN EQUAL JUSTICE ACT

  - WITNESSES INCLUDED THE JUSTICE DEPARTMENT, THE MENOMINEE TRIBE OF WISCONSIN, THE NAVAJO NATION, MASHANTUCKET PEQUOT NATION, MESCALERO APACHE TRIBE WHICH OPPOSED THE BILL

  - LAW FIRMS FROM CONNECTICUT, MASSACHUSETTS AND MINNESOTA TESTIFIED IN SUPPORT OF THE BILL, ALONG WITH ANON-INDIVIDUAL

- THE HEARING WAS THE THIRD ONE HELD ON THE TOPIC OF TRIBAL SOVEREIGN IMMUNITY, AND S. 1691, IMMUNITY-RELATED LEGISLATION INTRODUCED BY SENATOR GORTON. THIS BILL WOULD REMOVE TRIBAL DISCRETION AND DECISIONMAKING REGARDING WAIVERS OF IMMUNITY

  - THE BILL WOULD GIVE DISTRICT COURTS OF THE U.S. ORIGINAL JURISDICTION IN ANY CIVIL ACTION OR CLAIM AGAINST AN INDIAN TRIBE, WITH RESPECT TO WHICH THE MATTER IN CONTROVERSY ARISES UNDER THE CONSTITUTION, LAWS, OR TREATIES OF THE U.S.

  - BILL WOULD GIVE DISTRICT COURTS ORIGINAL JURISDICTION OF ANY CML ACTION OR CLAIM AGAINST AN INDIAN TRIBE FOR DAMAGES FOR CASES REGULATED TO CONTRACTS (BUT NOT A TORT) MADE BY A TRIBAL GOVERNING BODY OF THE INDIAN TRIBE OR ON BEHALF OF AN INDIANTRIBE

  - BILL WOULD GIVE DISTRICT COURTS ORIGINAL JURISDICTION FOR CIVIL ACTIONS IN CLAIMS AGAINST AN INDIAN TRIBE FORMONETARY DAMAGES, ACCRUING ON OR AFTER DATE OF ENACTMENT OFTHISACT

IS NORMALLY THE CASE.

- MARKUP ON THE INTERIOR APPROPRIATIONS SUBCOMMITTEE BILL FOR FISCAL YEAR 1999 WILL NOT OCCURUNTIL LATE JUNE

- ACCORDING TO SENATE INTERIOR APPROPRIATIONS STAFF, THE OUTLOOK FOR FISCAL YEAR 1999 ALLOCATIONS FOR INTERIOR WILL BE FLAT WHEN COMPARED TO FISCAL YEAR 1998, WITH POSSIBLE MODEST INCREASES, IF ANY. THEY ARE CONSIDERING PARTIAL STAFFING AT ANMC AND OTHER SITES

- THE HOUSE INTERIOR APPROPRIATIONS SUBCOMMITTEE STAFF IS LESS OPTIMISTIC THAN THE SENATE IN TERMS OF HOLDING AT FISCAL YEAR 1998 LEVELS. THE HOUSE BUDGET CHAIRMAN IS CONSIDERING REDUCED ALLOCATIONS FOR ALL APPROPRIATIONS SUBCOMMITTEE S. THE HOUSE INTERIOR APPROPRIATIONS SUBCOMMITTEE IS CONSIDERING PARTIALLY FUNDING OF MANDATORIES. THEY ARE ALSO CONSIDERING AN EXPANDED CAP ON CONTRACT SUPPORT COSTS BEYOND THE CAP IN THE FISCAL YEAR 1998 APPROPRIATIONS ACT TO COVER DECISIONS AND IMPACTS OF RECENT COURT CASES RELATED TO CONTRACT SUPPORT COSTS.

- S. 1770, THE BILL TO ELEVATE THE DIRECTOR OF IHS TO ASSISTANT SECRETARY LEVEL IS STILL PENDINGBEFORE THE SENATE INDIAN AFFAIRS COMMITTEE. TENTATIVE PLANS ARE TO HOLD A JOINT HEARING WITH THE HOUSE RESOURCE COMMITTEE THIS SUMMER

- REAUTHORIZATION OF THE INDIAN HEALTH CARE IMPROVEMENT ACT - PLANS ARE UNDERWAY TO HAVE AROUND TABLE ON HEALTH CARE ISSUES THAT TRIBES WOULD WANT TO CONSIDER DURING THE CONSULTATION PROCESS WHICH WILL OCCUR LATER THIS SUMMER AND FALL. THE ROUND TABLE IS SCHEDULED FOR EARLY JUNE, WITH A REPORT THAT WOULD BE USED TO STIMULATE DISCUSSION DURING THE CONSULTATION PROCESS.

KEY FACTS ON INDIAN HEALTH PROGRAMS

Prepared for the Indian Health Service Roundtable on Medicaid Managed Care

Sara Rosenbaum, J.D. and Ann Zuvekas, D.P.A

The George Washington University Medical Center
Center for Health Policy Research

March, 1996

KEY FACTS ON INDIAN HEALTH PROGRAMS [1]

1. Funding Levels, Selected Services, FY 1995 (ii millions)

Selected clinical services

Hospitals and health clinics	$822.5
Dentalservices	$57.5
Mental health services	$36.4
Alcohol and substance abuse services	$91.4
Contract health services	$362.6

Urban health

Urban clinics	$23.3
Total funding, selected services and activities	$1,393.7

2. Selected IHS and Tribal Facilities and Services

a. Total facilities and services

Hospitals	49 hospitals in 12 stat&
Health Centers	180 health centers in 27 states[3]
School health	8 school health centers
Health stations and clinics	273 health stations and satellite clinics in 18 states'
Substance abuse treatment	400 substance abuse treatment programs

b. Distribution of IHS facilities and services

Ten states -- Arizona, New Mexico, Nevada, California, Washington State, Alaska, Oklahoma, Montana, North Dakota, South Dakota and Minnesota -- account for over 80 percent of all IHS

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[1]Department of Health and Human Services, FY 19%. Justification of Estimates for Appropriations Committees (IHS/PHS, 1995); PHS/IHS Trends in Indian Health (1994).

'Nevada, Montana, Arizona, Alaska, Oklahoma, North Dakota, South Dakota, Minnesota, Mississippi, Nebraska, New Mexico, Nor&h Carolina

[3]Maine, New York, Florida, Louisiana, Oklahoma, Texas, Nebraska, Kansas, North Dakota, South Dakota, Montana, Idaho, Colorado, Wyoming, New Mexico, Utah, Arizona, Nevada, California, Washington, Oregon, Alaska, Iowa, Michigan, Minnesota, wisconsin and Alabama.

[4]South Dakota, North Dakota, Arkansas, Colorado, Minnesota, Michigan. Wisconsin, Montana, California, North Carolina, Louisiana, Mississippi, Arizona, Nevada, Washington, Idaho and Oregon.

and tribal hospitals and clinics.

c. Facilities operated by the IHS

Hospitals	40 hospitals
Healthcenters	64 health centers
School health	5 school health centers
Healthstations	50 health stations

d. Facilities operated by tribes and tribal organizations[5]

Hospitals	9 hospitals
Healtb centers and other outpatient sites	342 outpatient facilities including 116 health centers, 3 school health clinics, 56 health stations and satellite clinics and 167 Alaskan village clinics.
urban clinics	34 Urban Indian health clinics

3. Patients Served by IHS and Tribal Facilities and Programs

Total Indian service population	1.38 million (FY 1995). [6]
Total Indian user population (direct and contract services)'	1.26 million (FY 1995, est.)
Total number of hospital admissions, MS and tribal hospitals (direct and contract health services)	92,000 (1993)'
Hospital discharge rates per 1000 persons	71.3 (120.2 for the U.S.)[8]
Average length of stay per admission, MS and tribal	4.5 days (1993)[9]

[5]Under federal Medicaid law, all outpatient health programs and facilities operated by a tribe or tribal organization under the Indian Self Determination Act or an urban Indian organization receiving funds under Title V of the Indian Health Care Improvement Act are deemed to be federally qualified health centers for benefit coverage and payment purposes.

[6]21 percent are located in the Oklahoma City Am, followed by 15 percent in the Navajo area according to the Indian Health Service

[7]As with the general population, Indian admission rates have been declining. While the number of admissions to tribal direct and contract (CHS) facilities has increased, the majority of patients are found in IHS direct and contract (CHS) hospitals.

'*Indian Health* Service, *Trends in Indian Health, 1995* Table 5.9

[9] Ibid.

Total number of ambulatory medical visits, IHS and tribal	6.0 million (1993)[10]
Total number MS and tribal dental services	2.6 million (1994)"
Total number patient encounters, Urban Indian he&h programs	785,ooo (1993)[12]

4. Status of IHS and Tribal Facilities

Accreditation: all 49 IHS and triial hospitals are JCAHO accredited
Medicare certification: all MS hospitals are Medicare and Medicaid certified
Medicaid certification: all IHS health centers are Medicaid certified

5. Health Insurance Coverage Among Indians and Access to Health Care[13]

Indian families are significantly less likely to be insured than the population as a whole. Major disparities hold true regardless of work status.

Health Insurance Coverage of American Indians and Alaskan Natives by Percent (1987)

Employer coverage	Other private coverage	Medicaid coverage	Medicare coverage	Uninsured
25.5	2.6	11.4	6.3	54.9

Source: Health Care Coverage: Findings from the Survey of American Indians and Alaskan Natives (AHCPR, Research Findings #8)

[10]Since 1980 the number of ambulatory medical visits to E-IS direct health centers and other field clinics has remained relatively stable, while the number occurring at IHS direct hospitals has grown. The number of visits to IHS contract (CHS) providers has declined. The largest growth rate has been among visits at tribal clinics. *Trends in Indian Health, 1995, Table 5.11.*

[11]According to IHS these numbers have increased 25% *since 1970.*

[12]According to IHS these numbers have increased 123% since FY 1984.

[13]Data derived from the 1987 National Medical Expenditure Survey (NMES). In light of the significant decline in health insurance coverage since 1987 among the U.S. population, it is possible that these figures overstate the extent of health insurance coverage.

Health Insurance Status of Working Adults, spouses and children: SAIAN and U.S. Populations (1987)

Persons Under 65 in families with at least one employed adult (.578 million)	SAIAN population	U.S. population
All families with workers	36.2	75.4
Families with full-time workers	41.5	81.9
Families with part-time workers	23.4*	54.7

* Relative standard error greater than 30%.

Source: Health Care Coverage: Findings from the Survey of American Indians and Alaskan Natives (AHCPR, Research Findings #8)

Regardless of insurance status, American Indians tend to rely heavily on IHS services

Percent of SATAN Population with a Regular Source of Care Other Than an IHS Facility

All persons	All areas
Health care coverage	32.9
IHS only	
all year	12.2
part year	32.1
Other coverage all year	
any private	60.4
public only	44.7
Family Income	
poor	
low	31.6 17.6
middle	47.8
high	63.9

Source: Peter Cunningham, Health Cm Access, Utilization and Expenditures for American Indians and Alaskan Natives Eligible for the Indian Health Service, April, 1995 (Unpublished, Center for Studying Health System Change, Washington, D. C.

6. Major Patient Care Data Systems

- *The Inpatient* Care *System and the Contract Care System. Prepared* by IHS and tribal and CHS hospitals. Contains hospital inpatient data by various patient characteristics (age, sex, principal and other diagnoses, community of residence)

- *Ambulatory Patient Care System and the Contract Care System.* Reports on ambulatory visits to IHS and triial and CHS facilities by patient characteristics (age, sex, clinical impression, community of residence). Data compiled based on one record per visit.

- *Clinical Laboratory Workload Reporting System*

- *Pharmacy System*

- *Urban* **Projects** *Reporting System*

- *Dental Data System*

- *IHS Patient Registration System* (contains demographic data on persons that access the IHS and tribal system.)

- *Community* **Services** (e.g., Public Health Nursing, Nutrition, CHR's)

7. **Relationship of Indian and Tribal Facilities and Services to the Medicaid Program**

a. Federal financial contribution for covered services furnished by facilities operated by the Indian Health Service or a tribe or tribal organization

- Section 1905(b) provides that federal financial participation (FFP) is 100 percent "with respect to amounts expended as medical assistance for services which are received through an Indian Health Service Facility, whether operated by the Indian Health Service or by an Indian tribe or tribal organization."

- Medical assistance furnished by IHS or tribal contract providers are reimbursed at normal FFP rates and does not qualify for 100 percent FFP.

b. Relationship between Indian health service providers and the federally qualified health centers program

- Section 1905(l), which defines federally qualified health centers, provides that FQHCs

include "an outpatient health program or facility operated by a tribe or tribal organization under the Indian Self Determination Act or an urban Indian organization receiving funds under Title V of the Indian Health Care Improvement Act". As FQHCs tribal organization clinics and urban Indian clinics are entitled to reimbursement for the reasonable cost of care furnished to Medicaid beneficiaries. FQHC services are a mandatory service to which eligible individuals are entitled,

- A tribal contract clinic would not be considered an FQHC unless it otherwise met the requirements of the FQHC statute.

- An MS direct operation or contract outpatient clinic would not be considered an FQHC (although all services furnished by MS direct operation clinics would be eligible for 100 percent FFP). MS clinic services are not a mandatory covered service as are FQHC services, and the special managed care rules under Section 1915 and Section 1115 demonstrations that apply to FQHCs (see below) would not apply to MS clinics.

8. Treatment of Indian Health Programs that are Federally Qualified Health Centers under Section 1115 and Section 1915 Mandatory Managed Care Demonstrations

***a.* Section 1915** *demonstrations*

- The FQHC service requirement may not be waived in a Section 1915 mandatory Medicaid managed care freedom-of-choice waiver. Therefore, Indian Health clinics that are FQHCs remain covered on a mandatory basis and are eligible for the reasonable cost of care they furnish. Note, however, that HCFA guidelines implementing Section 1915 provide states with discretion to limit access to FQHC services in the case of enrollees who select a plan that includes no FQHCs so long as they could have selected a plan with participating FQHCs.

b. *Section 1115 demonstrations*

- The Secretary may waive FQHC mandatory service coverage and reasonable cost payment rules in a Section 1115 waiver and has frequently done so (see accompanying materials on Section 1115). However, conditions of approval under certain demonstrations include supplemental payments to FQHCs to compensate for the loss of revenues as a result of participation in risk-based managed care systems that do not pay on a reasonable cost basis. Indian tribal organization and urban Indian clinics that are FQHCs would be covered by all conditions applicable to FQHCs in Section 1115 demonstration states.

- The Secretary can elect to apply waiver conditions applicable to other IHS programs (IHS direct or contract providers and tribal contract providers).

9. The Role of Medicaid in Funding IHS Operations

- $107 million in Medicaid collections represents 6.3% of the FY95 appropriations for the Indian Health services program".

10. Legal Authority of Indian Health Programs to Enter Into Risk Agreements Under Medicaid

- Under the Anti-Deficiency Act, 31 U.S.C. §1341, a Federal employee may not incur obligations in advance of or in excess of appropriations. As a result, contractual managed care obligations to furnish care to an enrolled population for a fixed premium that might not cover the cost of services under the contract would constitute a violation of the Act according to the Office of General Counsel, HHS.[15] However, if the contract conditions IHS obligations on the appropriation of federal funds by Congress, there would be no violation.[16] Moreover, contractual specifications that permit the IHS to adjust service obligations to remain within the available budget would also allow the agency to avoid violation of the Act. Third, a managed care contract that provides reasonable cost reimbursement would not violate the Act." Finally, stop-loss arrangements with the state, in combiition with authority to limit benefits in light of budget constraints, might also avoid violation of the Act.[18]

- Because the Anti-Deficiency Act applies only to federal employees and not to tribal contractors, there is no bar to tribal participation in managed care under the Act.[19]

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[14]Telephone conversation with Harell Little, Special Assistant to the Director of the Office of Health Programs. Data source: Department of Health and Human Services, Indian Health Service, FY95 Justification of Estimate for Appropriations Committees, p. IHS-2.

[15]Memorandum from Barbara Hudson to Richard McClosky (February 13, 1995).

[16]Id.

[17]Id.

[18]Were the IHS facility permitted under a managed care contract with a state Medicaid program to reduce covered benefits rather than incur losses, other questions might arise under the Medicaid statute. The state's obligation to furnish mandatory benefits of sufficient amount duration and scope to individuals is not extinguished by their enrollment in a managed care plan; hence, the state might be liable for coverage of services that are reduced by the Indian health plan. Moreover, comparability issues might arise were services to be reduced for individuals enrolled in an IHS plan compared to individuals enrolled in other health plans that are not permitted to renegotiate the scope of their service agreements in the event that the premium is insufficient to cover their costs.

[19]Hudson, op. Cit.

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, O.C. 20201

SPECIAL

AUG 7 1997

TO: Heads of Operating Divisions
Heads of Staff Divisions

FROM: The Secretary

SUBJECT: Department Policy on Consultation with American Indian/Alaska Native Tribes and Indian Organizations

The President's Memorandum of April 29, 1994, titled, "Government-to-Government Relationship with Native American Tribal Governments" that was ssnt to the heads of executive departments and agencies reaffirmed the unique relationship between the U.S. Government and Native American Tribal Governments as stated in the Constitution, treaties, statutes and court decisions and directed each executive department and agency to consult with tribal governments prior to taking actions that affect them.

The Domestic Policy Council (DPC) Working Group on Indian Affairs, chaired by Secretary Babbitt, has requested that each Department develop its own operntional definition of 'consultation" with Indian tribes to meet the requirements of' both the Indian Self-Determination and Educational Assistance Act, Public Law 93-638, and the President's Memorandum.

The DPC's recommendations led to the creation of an HHS Working Group on Consultations with American Indians and Alaska Natives. Co-chaired by Jo Ivey Boufford, M.D., former Acting Assistant Secretary for Health, and Michael H. Trujillo, M.D., Director, Indian Health Service, this group was comprised of representatives of the Department's major Operating Divisions and Office of the Secretary Staff Divisions [OPDIV/STAFFDIV]. During several meetings, the group explored the broad array of American Indian and Alaska Native (AI/AN; programs within the Department and developed a report recommending a Department-wide consultation plan (attached). i have accepted the Working Group's recommendations in the attached report and have designated the OS/Office of Intergovernmental Affairs (IGA) as the lead for the Department. As stated in the Working Group's report, each OPDIV/STAFFDIV should develop their own individualized consultation plan consistent with HHS policy. Completed plans should be submitted to IGA by August 29. Each OPDIV/STAFFDIV should submit an annual progress report on consultations conducted during the previous fiscal year to IGA no later than December 31 of each year.

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TRACER

I know all of you share with me a commitment to ensure-that the intent and spirit of the President's Memorandum is fully embraced in the consultation process that we are implementing.

Donna E. Shalala

Attachment

TAB A: Working Group Report

DEPARTMENT OF HEALTH AND HUMAN SERVICES WORKING GROUP REPORT ON CONSULTATION WITH AMERICAN INDIANS AND ALASKA NATIVES REPORT

SUMMARY AND RECOMMENDATIONS

I. INTRODUCTION

The Domestic Policy Council (DPC) Working Group on Indian Affairs chaired by Secretary Babbitt has requested that each department develop its own operational definition of "consultation" with Indian tribes to meet the requirements of both the Indian Self-Determination and Educational Assistance Act, Public Law (P.L.) 93-638, and the April 29, 1994, Executive Memorandum on Government-to-Government Relations with Native American Tribal Governments. Each department should also develop mechanisms to ensure that Native American tribal governments are given an opportunity to provide input on department plans and that the approach decided upon is clearly communicated to Indian communities.

The United States (U.S.) government and the governments of American Indians and Alaska Natives (AI/AN or Indian people) have a "government-to-government" relationship based on the U.S. Constitution, treaties, Federal statutes, court decisions, and Executive Branch policies, as well as moral and ethical considerations. This special relationship also constitutes a trust relationship between these two governments. Certain benefits provided to Indian people through Federal legislatively enacted programs flow from this trust relationship. These benefits are not based upon race, but rather, are derived from the government-to-government relationship. A vital component of this relationship is consultation between the Federal and tribal governments. In cases where the government-to-government relationship does not exist, as with urban Indian centers, Inter-tribal organizations, state recognized tribal groups, and other Indian organizations, consultation is encouraged to the extent that there is not a conflict-of-interest in the above stated Federal statutes or the Operating Division/Staff Division (OPDIV/STAFFDIV) authorizing legislation. Some aspects of this consultation are set out in statute and administrative policy.

II. FOUNDATIONS

A. Federally Recognized Tribes

The special relationship between the U.S. government and tribal governments is grounded in many historical, political, legal,

moral, and ethical considerations. Increasingly this special relationship has emphasized self-determination for Indian people and meaningful involvement by Indian people in Federal decision making (consultation) where such decisions affect Indian people, either because of their status as Indian people or otherwise.

Consultation examples include:

1. A provision in the Indian Self-Determination and Education Assistance Act, P.L. 93-538, as amended, codified at 25 U.S.C. 450a states that:

"(a) Congress. .. recognizes the obligation of the United States to respond to the strong expression of the Indian people for self-determination by assuring maximum Indian participation in the direction of . . . Federal services to Indian communities so as to render such services more responsive to the needs and desires of those communities."

"(b) The Congress declares its commitment to the maintenance of the Federal government's unique and continuing relationship with, and responsibility to, individual Indian tribes and Indian people as a whole through . .. effective and meaningful participation by the Indian people in the planning, conduct, and a iministration of those programs and services.'

2. Regulations implementing the Indian Self-Determination *Act,* as amended, contain the iollowing provisions:

25 C.F.R. 900.3(a)(2):" Congress has declared its commitment to the mainte lance of the Federal government's unique and continuing relationship with, and responsibility to, individual Indian tribes and to the Indian people as a-whole through the establishment of meaningful Indian self-determination policy which will permit an orderly transition from the Federal domination of programs for, and-services to, Indians to effective and meaningful participation by the Indian people in the-planning, conduct and administration of. those programs and services ."

25 C.F.R. 900.3(b)(l): "It is the policy of the Secretary to facilitate the effort of Indian tribes and tribal organizations to plan, conduct, and administer programs, functions, services and activities, or portions thereof, which the departments are authorized to administer for the' benefit of Indians because of their status as Indians ...."

3. The Indian Health Care Improvement Act, P.L. 94-437,

contains a "Congressional Finding[]," codified at 25 U.S.C. 1601, that:

'(b) A major national goal of the United States is to provide the quantity and quality of health services which will permit the health status of Indians to be raised to the highest possible level and to encourage the maximum participation of Indians in the planning and management of those services."

4. The Unfunded Mandates Reform Act of 1995, P.L. 104-4 states:

Section 2. "The purposes of this Act are ... to assist Federal agencies in their consideration of proposed regulations affecting ... Tribal governments by. .. requiring that Federal agencies develop a process to enable . . . .Tribal governments to provide input when Federal agencies are developing regulations,' and requiring that Federal agencies prepare and consider the budgetary impact of Federal regulations containing Federal mandates upon ... Tribal governments before adopting such regulations."

5.- The President's Memorandum of April 29, 1994, to heads of executive departments and agencies titled, "Government-to-Government Relations with Native American Tribal Governments," outlines the concepts of consultation (Attached).

B. Non Federally Recognized Tribes and Other Native American People

Indian people are often significantly or differentially affected by the Department of Health and Human Services (HHS) actions, may have special needs that HHS policy makers may not be sensitive to, may make especially valuable contributions to policy formulation and program administration because of their unique perspectives, and may be expressly mentioned *in* HHS statutes, or need to be effectively and-efficiently served as a part of the HHS' mission.

Although the special "tribal-federal" relationship is based in part on the government-to-government relationship, other statutes and policies exist that allow for consultation with non-federally recognized tribes and other Indian organizations that, by the mere nature of their business, serve Indian people and might be negatively affected if excluded from the consultation process. Specifically:

1. A statute administered by the Indian Health Service (IHS), 25 U.S.C. 1653, requires the Secretary of HHS to enter into

contracts with or issue grants to urban Indian organizations to assist such urban centers for the provision of health care and referral services for urban Indians residing in the urban centers in which such organizations are situated. (42 U.S.C. 1654 authorizes grants and contracts with urban Indian organizations to determine the health status and unmet health needs of urban Indians.)

2. A statute administered by the Administration for Native Americans (ANA), Sec. 802. (42 U.S.C. 2991b], provides financial assistance for Native American projects including but not limited to, governing bodies of Indian tribes on Federal and State reservations, Alaska Native villages and regional corporations established by the Alaska Native Claims Settlement Act, and such public and nonprofit agencies serving Native Hawaiian, and Indian and Alaska Native organizations in urban and rural areas that are not Indian reservations or Alaska Native villages, for projects pertaining to the purposes of this title. The Commissioner is authorized to provide financial assistance to public and nonprofit private agencies serving other Native American Pacific Islanders (including American Samoan Natives) for projects pertaining to the purposes of this act. In determining the projects to be assisted under this title, the Commissioner shall consult with other Federal agencies for the purposes of eliminating duplication or conflict among similar activities or projects and for the purpose of determining whether the'findings resulting from. those projects may be incorporated into one or more programs for which those agencies are responsible. Every determination made with respect to a request for financial assistance under this section shall be made without regard to whether the agency making such request serves, or the project to be assisted is for the benefit of, Indians who are not members of a federally recognized tribe .. . ." The statute (42 U.S.C. 2991b-2(c)(2)) also requires that the Administration for Native Americans (ANA) Commissioner, "serve 'as-an effective and visible advocate for Native Americans . . .;" while 42 U.S.C. 2991b-2(d) establishes, in the Office of the Secretary, the Intra-Departmental Council on Native American Affairs. Among its responsibilities, 42 U.S.C. 2991b-2(c)(3) requires that this Council assist the Commissioner in "coordinating activities within the department leading to the development of policies, programs, and budgets, and their administration that directly affect Indian and other Native populations ...."

3. A statute administered by the Administration for Children and Families that establishes .the Low Income Home Energy Assistance Program (42 U.S.C. 8621 et seq.) and its implementing regulations (45 C.F.R. 96.48) make clear that

Federal and State recognized tribes may receive direct funding under this block grant.

4. A statute administered by the Health Resources and Services Administration that establishes the Centers of Excellence in the Minority Health Program (42 U.S.C. 293c(c)(4), (d)(3), (e) provides for the funding of programs in health professions education at Native American Centers of Excellence.

Other HHS components that rely on more general statutory consultation language conduct activities that directly affect Indian people.

III. THE DOMESTTC POLICY COUNCIL (DPC) WORKING GROUP ON AMERICAN INDIAN/ALASKA NATIVE AFFAIRS CONSULTATION PROCESS

In response to the President% 1994 Memorandum, the DPC's Working Group on Indian Affairs led by the Secretary of the Interior established a subgroup to develop a consultation policy, After nearly 2 years of analysis and deliberations toward devising a uniform, Government-wide consultation policy, the DPC concluded that such uniformity was undesirable given the different organizational structures, statutory considerations and administrative processes between Federal departments and agencies. Therefore, the DPC recommended that each department be charged with developing its own individualized consultation policy/plan. The DPC drafted guidelines identifying six points that should be addressed by each department's consultation policy/plan:

1. Each department will develop a general department-wide AI/AN policy/plan that outlines its general direction on consultation.

2. Each department will develop its own methods of consultation based on its internal requirements using tools that it has available.

3. As part of the decision-making process. for major issues that affect AI/ANs, each department will develop a short "consultation plan" that will indicate to tribal governments how, for example, consultation in general, and time frames would be carried out on a particular issue.

4. Each department will include an appropriate plan for the receipt of input, allowing for adequate response time, on AT/AN appropriation needs before the department submits its fiscal budget to the Office of Management and Budget. Each department should encourage tribal government input in its. budget formulation process so that it may be useful to their

decision-making.

5. Each department will utilize either the Codetalk Home Page or its own Home Page (with a link to Codetalk) to make its consultation plan known to the tribes and the public. Each department should also use its Home Page to solicit tribal government comments on its consultation plan. Finally, each department should have its own American Indian/Alaska Native Policy Statement available at the same Home Page source.

6. Each "consultation plan" should include sufficient time and access SO that tribes may provide input before a final decision is made.

IV. HHS AI/AN CONSULTATION PROCESSES AND RECOMMENDATIONS

The DPC's recommendations on departmental policy formulation led to the creation of an HHS Working Group on Consultations with American Indians and Alaska Natives. Co-chaired by Jo Ivey Boufford, M.D., former Acting Assistant Secretary for Health, and Michael H. Trujillo, M.D., Director, Indian Health Service (IHS). This group is comprised of representatives from the department's major Operating Divisions and Office of the Secretary Staff Divisions (OPDIV/STAFFDIV). During several meetings, the group explored the broad array of AI/AN programs within the department that resulted in a departmental report, "Improving the Health and Well-Being of American Indians and Alaska Natives." This report is'a summary of each OPDIV/STAFFDIV's 1995-1996 activities and/or programs for AI/AN people.

The HHS Working Group also reviewed each OPDIV/STAFFDIV's current approach(es) to consultation, and worked to develop recommendations for a departmental approach to consultation that could be forwarded to the Secretary. The working group recommended that the department's Consultation Plan consist of the individual OPDIV/STAFFDIV plans and any department-wide consultation processes as deemed necessary.

V. RECOMMENDATIONS

A. HHS APPROACH TO CONSULTATION

Based on the HHS Working Group deliberations and review of work accomplished by IHS, the following definition of "consultation" is proposed for HHS use:

> "Consultation is an enhanced form of communication which emphasizes trust, respect and shared responsibility. It is an open and free exchange of information and opinion among parties which leads to mutual understanding and

comprehension. Consultation is integral to a deliberative process which results in effective collaboration and informed decision making."

It is recommended that the policy of this Department be:

1. To consult with Indian people to the greatest practicable extent and to the extent permitted by law before taking actions that effect these governments and people;

2. To assist States in the development and implementation of mechanisms for consultation with their respective tribal governments and Indian organizations before taking actions that affect these governments and/or the Indian people residing within their state. Consultation should be conducted in a meaningful manner that is consistent with the definition of 'consultation" as defined in this policy, including reporting to the appropriate HHS agency on its findings, and on the results of the consultation process that was utilized;

3. To assess the impact of this Department's plans, projects, programs and activities on tribal and other available resources;

4. To remove any procedural impediments to working directly with tribal governments or Indian people; and

5. To work collaboratively with other Federal agencies in these efforts..

B. DEPARTMENTAL-LEVEL ACTIONS

1. Consistent with the-thrust of the DPC guidance on budget consultation, it is recommended that the Office of Intergovernmental Affairs (IGA), IHS, ANA, and the Office of Minority Health (OMH), convene for the department, an annual meeting of Indian people to present their appropriation needs and priorities. The OPDIVs and STAFFDIVs are encouraged to suggest participants that should be included in attendance. This meeting should take place before the submission by OPDIVs/STAFFDIVs of their budget requests to the department (probably in May of each year). The Assistant Secretary for Management and Budget and other appropriate OPDIVs/STAFFDIVs will have representatives at this meeting to ensure that these needs and priorities are made known to the members of the department's Budget Review Board.

Before the annual meeting, a brief, clear document

summarizing the preceding year's departmental budget should be made available as a basis for discussion to all potential consultation participants. Before or after this meeting,. OPDIVs/STAFFDIVs who wish to conduct consultation on the fiscal year budgets specific to their programs or-other OPDIV/STAFFDIV activities relevant to AI/AN, are encouraged to do so (the proposed approach should be outlined in the specific OPDIV/STAFFDIV consultation policy/plan).

2. The department should determine if there are other issues *or* priorities for legislation *or cross* cutting initiatives that require department level consultation and develop a process for such consultation, otherwise, the processes developed by each OPDIV/STAFFDIV should be aggregated as the departmental process and communicated appropriately.

3. The department will designate a single point-of-contact that can provide AI/AN representatives with access to departmental program information and assistance. This function will be located *in* the OS/IGA, linked to HHS Regional Offices for field follow-up/contact.

C. OPDIV/STAFFDIV LEVEL ACTIONS

RECOMMENDATIONS:

1. Each OPDIV should prepare a draft policy/plan for a consultation process. The OS should be considered *an* OPDIV for these purposes so that STAFFDIVs may consult as a group and develop an integrated, cross-cutting consultation process. This draft will be reviewed by the Working Group for comment and by the Office of the General Counsel for any legal issues. The Assistant Secretary for Management and Budget would be considered the lead for the annual Department-wide budget consultation described above.

2. Each OPDIV (and STAFFDIV) should consult with AI/AN leaders on their "reviewed" policy/plan (see IHS "Tribal Consultation and Participation Policy," (Attachment A).

3. Each OPDIV (and STAFFDIV) policy/plan should include:

A specific delineation of the issues on which advice/consultation will be sought *or* criteria that will be used to identify the issues. In general, budget matters and legislation affecting tribes are considered critical for consultation. The OPDIVs/STAFFDIVs which have difficulty with this item may wish to conduct a focus group of AI/AN representatives to recommend the kinds of items on which consultation should be conducted.

A provision that seeks to ensure that the OPDIV/STAFFDIV will assist States in the development and implementation of mechanisms for consultation with their respective tribal governments and Indian organizations before taking actions that affect these governments and/or the Indian people residing within their State. Consultation should be conducted in a meaningful manner that is consistent'with the definition of 'consultation" as defined in this policy, including reporting to the appropriate HHS agency on its findings, and on the results of the consultation process that was used.

A mechanism by which the OPDIV/STAFFDIV will evaluate the States efforts in compliance with the consultation process with tribal governments and Indian organizations.

Guidelines that define how the OPDIV/STAFFDIV will address States in situations where the evaluation has identified deficiences in the consultation process as set forth in this policy.

A defined process for early inclusion of tribal governments and other Indian people in the decision-making process;

Specific mechanisms that will be used to consult with tribal governments. In consultation with tribal governments and other Indian people, the decision could be made to use IHS or other mechanisms such as intermediate national or regional organizations and conferences, or establish specific structures for ongoing advice from Indian communities.

4. Consultation process: Further, each OPDIVs/STAFFDIVs plan should also provide:

Sufficient background information to assure a thorough understanding of each *issue* on which consultation is requested, including a clear statement of the potential impact of the proposed action on Indian people.

A clear statement of the advice requested.

A specific time frame for response from consulted entities.

A clear indication of who should receive the reply.

5. Upon completion of consultation, there may be issues that would benefit from ongoing involvement of Indian people in implementation and evaluation. The OPDIV/STAFFDIV plans should include mechanisms to address this need.

Timely feedback should be provided to Tribes and Indian organizations on the resolution of the issue for which consultation was requested.

6. The consultation process-when finalized should be-displayed on the OPDIV/STAFFDIV's Home Page and on OMH's Association of American Indian Physicians (AAIP) Home Page, which already connects to the IHS Home Page and should be connected to the HHS and Codetalk Home Pages. It was noted that assuring adequate consultation may require the investment of resources by the OPDIVs/STAFFDIVs, such as provision of training, detailing of staff or providing information technology to tribal governments and other Indian people. In instances where computer capabilities are absent, OPDIVs/STAFFDIVs should attempt to disseminate information by other media mechanisms such as the telephone, newspaper, magazines, newsletters, etc.

7. Establishment of a single point-of-contact for tribal governments and other Indian people within each OPDIV/STAFFDIV at a level with access to information of all the OPDIVs/ STAFFDIVs operating components and programmatic levels is recommended. This will assist the department's point of contact in the IGA in accessing department-wide information and aid in providing a single entry point to HHS-wide information.

8. Each OPDIV/STAFFDIV will submit to the IGA by December 31 an annual report on the previous fiscal years'consultation' activities addressing how each point in their plan was implemented for each consultation conducted.

VI. SUMMARY

We have endeavored to consider a wide range of OPDIV/STAFFDIV needs and unique characteristics in crafting these guidelines. As there is variability among the OPDIVs/STAFFDIVs, there is also a need to allow for variability over time. Hence, it is important that consultation plans developed by OPDIVs/STAFFDIVs remain dynamic, changing as circumstances and AI/AN input indicate. Once the Department has its basic consultation policy in place, it should seek to integrate its efforts with those of other departments and agencies. Such intra-governmental coordination will benefit the departments and agencies as well as AI/ANs.

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